

Case Number:	CM15-0071973		
Date Assigned:	04/22/2015	Date of Injury:	10/02/2012
Decision Date:	06/18/2015	UR Denial Date:	04/01/2015
Priority:	Standard	Application Received:	04/15/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York
 Certification(s)/Specialty: Anesthesiology

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 57 year old female who sustained an industrial injury on 10/2/12. The diagnoses have included complex regional pain disorder of the lower extremity, ankle sprain/strain, right knee strain, depressive reaction and anxiety. Treatment to date has included medications. There were no other treatments noted. The current medications included Clonazepam, Flexeril, Hydrocodone, Ibuprofen, Lyrica, Promethazine, Requip, Voltaren gel and Zolpidem. Currently, as per the physician progress note dated 3/27/15, the injured worker complains of left ankle pain and right knee pain. The ankle pain has remained unchanged at 8/10 on pain scale and the right knee pain has decreased from last visit with 8/10 to current visit rated 6/10. She reports that the medications allow her to carry out and perform her activities of daily living (ADL) and help with her anxiety. The exam of the right knee revealed tenderness in the posterior knee area. The left extremity exam revealed atrophy of the left calf, decreased range of motion in the left ankle, left foot is colder in comparison to the right, left foot was hypersensitive to touch, tenderness was noted, she favors the left leg and limps with ambulation and there was decreased range of motion with right knee pain. There was no urine toxicology noted. The physician noted that she was to continue with medications, psychological/psychiatric evaluation and return in 1 month. The physician requested treatments included Clonazepam 0.5mg quantity unspecified, Lyrica 50mg quantity 90, Voltaren gel 2gms and Hydrocodone Acetaminophen 10/325mg quantity 90.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Clonazepam 0.5mg quantity unspecified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Benzodiazepines.

Decision rationale: According to CA MTUS Guidelines, benzodiazepines are prescribed for anxiety. They are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Clonazepam (Klonopin) is a long-acting benzodiazepine, having anxiolytic, sedative, and hypnotic properties. Most guidelines recommend the use of Clonazepam for the treatment of anxiety disorders, and as an adjunct treatment for anxiety associated with major depression. Use of this medication is limited to four weeks. There are no guideline criteria that supports the long-term use of benzodiazepines. In this case, there was no documentation of the indication and duration of use. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Lyrica 50mg quantity 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti Epilepsy Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica Page(s): 58.

Decision rationale: According to California MTUS Guidelines, anti-epilepsy drugs (AEDs) are a first-line treatment for neuropathic pain. Lyrica is FDA approved for diabetic neuropathy and post-herpetic neuralgia and has been used effectively for the treatment of other neuropathic pain. The guidelines indicate a good to moderate response to the use of Lyrica is a 30-50% reduction in pain. This patient has been taking Lyrica, without documentation of significant improvement. Without evidence of improvement, the guidelines recommend changing to a different first-line agent (TCA, SNRI or AED). Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Voltaren gel 2gms: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 91-97.

Decision rationale: According to the California MTUS Guidelines, Voltaren Gel 1% (Diclofenac) is indicated for the relief of osteoarthritis in joints that lend themselves to topical treatment, such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. The maximum dose should not exceed 32 g per day. The submitted documentation does not indicate that the injured worker had a diagnosis of osteoarthritis. Additionally, the efficacy of the medication was not submitted for review, nor was it documented that it helped with any functional deficits that the injured worker had to the right knee/left ankle. In addition, there was no dosage specified for the requested medication. Medical necessity for the requested topical gel has been not established. The requested Voltaren Gel is not medically necessary.

Hydrocodone Acetaminophen 10/325mg quantity 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's functional benefit. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.