
Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/15/2013
Date of Injury: 9/18/2010
IMR Application Received: 8/9/2013
MAXIMUS Case Number: CM13-0008971

Dear Mr./Ms. [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 physician 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/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

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

The claimant is a 43-year-old gentleman injured 08/19/2010. He was with initial complaints of low back pain. The most recent clinical assessment is a 07/01/2013 orthopedic evaluation with [REDACTED], MD, indicating ongoing complaints of low back pain with radiating leg pain most noted to the right thigh. Physical examination showed a positive right-sided straight leg raise, tenderness to palpation over the right paraspinal musculature and no other significant findings. It states he has been treated conservatively with physical therapy, anti-inflammatory agents, and a back brace with no significant benefit. Epidural steroid injections were recommended at that time at the L3-4, L4-5, and L5-S1 level for further therapeutic treatment. He was also refilled medications in the form of Vicodin, Voltaren, and continued with current work restrictions. Other forms of medication management are not noted. A formal diagnosis was not given at that assessment. Previous assessment of 06/25/2013 gave the claimant a diagnosis of post-traumatic stress disorder, depressive disorder, and sleep disorder. A previous impairment rating evaluation on 03/11/2013 gave the claimant a diagnosis of lumbosacral chronic strain with disc protrusion, bilateral knee chronic strains, status post open reduction and internal fixation of a right distal tibia and fibula fracture with iliac crest bone grafting. Formal imaging is not documented for review.

IMR DECISION(S) AND RATIONALE(S)

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

1. 1 prescription of Voltaren 1% #100 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pages 111-112, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Based on California MTUS, Chronic Pain Medical Treatment Guidelines, Voltaren 1% gel in this case would not be indicated. Guidelines indicate that the role of Voltaren gel is indicated for the relief of osteoarthritic pain to joints that lend themselves to topical treatment, i.e. the ankle, elbow, hands, knees, and wrists. It is not indicated for treatment of the spine, hip, or shoulder. The employee's current diagnosis is that of a chronic strain to the shoulder and chronic strains to the knee with no documented evidence of osteoarthritic change to the knee given. While the employee is noted to be status post a prior open reduction and internal fixation to the tibia, the absence of documented diagnosis of knee osteoarthritis would not support the role of Voltaren topical gel. As stated above, guidelines do not indicate the use of this agent for use in lumbar complaints. This would clearly negate its role for the employee's diagnosis of chronic lumbar strain as well. **The request for 1 prescription of Voltaren 1% #100 is not medically necessary and appropriate.**

2. 1 prescription of Vicodin #60 with 2 refills is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Pain Medical Treatment Guidelines, Opioids for Chronic Pain, page 80, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Based on California MTUS, Chronic Pain Medical Treatment Guidelines, continued role of Vicodin with 2 refills in this case would not be supported. Guidelines in regard to the role of opioids in chronic pain setting, particularly that of chronic back pain indicate that efficacy of short-acting agents is limited and long-term efficacy beyond the use of 16 weeks is unclear. This is an employee with current diagnosis of chronic lumbar strain and chronic knee strain with no documented physical examination findings or clinical imaging demonstrating compressive neurologic process. It would be unclear as to why continued role of short-acting narcotics would be indicated at this chronic stage in the clinical course of care. The clinical records for review also fail to demonstrate significant improvement or benefit of symptoms based on subjective pain scores or improvement on subjective complaints or objective findings on examination at present. The continued role of this agent, which is being requested for a 3 month supply, 60 pills 2 refills, would clearly exceed guideline criteria, which would not support the role of short-acting agents for greater than 16 weeks of use. **The request for 1 prescription of Vicodin #60 with 2 refills is not medically necessary and appropriate.**

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

[REDACTED]

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