

Case Number:	CM13-0003364		
Date Assigned:	06/06/2014	Date of Injury:	03/29/1991
Decision Date:	08/27/2014	UR Denial Date:	07/10/2013
Priority:	Standard	Application Received:	07/25/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 74-year-old female with a date of injury of 3/29/99. The mechanism of injury is not provided within the documentation available for review. The injured worker's diagnoses included cervical spondylosis, lumbar spondylosis, and fibromyalgia. Previous conservative care includes physical therapy and injections. Surgical history includes a cervical fusion at C6-7. The injured worker's range of motion revealed to be within functional limits, flexion is within functional limits, and bilateral side bending and rotation are limited by 50%. The injured worker is tender to palpation in the suboccipital region extending down the paraspinals and levator scap and trap into the parascapular region. In addition, the injured worker presented with positive Spurling's distraction, with pain rated at 9/10. The injured worker's medication regimen included hydrocodone, Biofreeze, Lidoderm patches, Voltaren gel, and Lyrica.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE (11/3/2011) HYDROCODONE-ACETAMINOPHEN 5-500MG TABLET: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

Decision rationale: The California MTUS Guidelines state that the ongoing management of opioids should include the ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The clinical documentation provided for review indicates the injured worker has utilized hydrocodone prior to 2011. There is a lack of documentation in therapeutic and functional benefit and ongoing use of Norco. There is a lack of documentation related to the ongoing review of pain relief, functional status, appropriate medication use, and side effects. The clinical note from 11/3/11 was not provided within the documentation available for review. Therefore, the retrospective request is not medically necessary.

VOLTAREN 1% GEL: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The California MTUS Guidelines recommend topical analgesics as an option, although they are largely experimental in use with few randomized controlled trials to determine effectiveness or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In addition, the guidelines state that Voltaren gel 1% is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip, or shoulder. The documentation indicates the injured worker was being treated for cervical and lumbar spondylosis. The guidelines do not recommend Voltaren gel for the spine. Therefore, the request is not medically necessary.

RETROSPECTIVE (11/3/2011) LANSOPRAZOLE (PREVACID) 30MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, G.I. symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & Cardiovascular Risk.

Decision rationale: The California MTUS Guidelines recommend patients at intermediate risk for gastrointestinal events and no cardiovascular disease a non-selective NSAID with either a PPI (proton pump inhibitor), misoprostol, or a COX-2 selective agent. Long term PPI use has been shown to increase risk of hip fracture. To determine if the patient is at risk for gastrointestinal events, documentation should include age greater than 65 years; history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or an

anticoagulant; or high dose multiple NSAID use. The clinical information provided for review lacks documentation related to any gastric events or signs and symptoms. According to the documentation provided for review, the injured worker has utilized Prevacid prior to 2011. There is a lack of documentation related to the therapeutic and functional benefit related to the use of Prevacid. Therefore, the retrospective request is not medically necessary.

RETROSPECTIVE (11/3/2011) ALEVE 220MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, (non-steroidal anti-inflammatory drugs) Page(s): 67.

Decision rationale: The California MTUS Guidelines recommend NSAIDs for chronic low back pain as an option for short term symptomatic relief. The clinical documentation provided for review indicates the injured worker utilized Aleve prior to 2011. There is a lack of documentation related to the functional benefit in the utilization of Aleve. In addition, there is a lack of documentation related to the injured worker's functional deficits to include range of motion values in degrees and the utilization of a VAS pain scale. In addition, the request as submitted failed to provide the frequency and directions for use. Therefore, the retrospective request for (11/03/2011) Aleve 220 mg is non-certified.