MAXIMUS Federal Services

Case Number:	CM13-0058428		
Date Assigned:	12/30/2013	Date of Injury:	10/01/2011
Decision Date:	04/30/2014	UR Denial Date:	10/02/2013
Priority:	Standard	Application Received:	10/31/2013

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, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in Maryland. 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 patient is a 61-year-old who had a work injury dated October 1, 2011.The diagnoses include cervical spine strain/sprain with left upper extremity radiculitis, thoracic spine musculoligamentous strain, lumbar spine musculoligamentous strain, left shoulder periscapular strain, right elbow sprain, bilateral knee patellofemoral arthralgia. There are requests for the medical necessity of Voltaren XR 100mg #30; Fexmid 7.5mg #60; Prilosec 20mg #30; and 2 months rental for interferential unit and supplies. A primary treating physician progress report dated March 12, 2014 revealed that the patient had complaints of neck symptom which are described as "improved, mild, aching, cramping and having weakness." The secondary complaints are low back, right shoulder, right elbow and both knees. The physical exam revealed tender cervical and lumbar paraspinals. There is decreased sensation in the left C6,C7 dermatomes. There is decreased cervical and lumbar range of motion. The straight leg raise test is negative. The right shoulder reveals tenderness is supraspinatus. There is a positive impingement sign.The treatment plan includes continuing a home exercise program and aquatic therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF VOLTAREN XR 100MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Section Page(s): 67-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain : Diclofenac Sodium VoltarenÂ®, Voltaren-XRÂ®) and Diclofenac

Decision rationale: Per documentation the patient has been prescribed Voltaren (Diclofenac) XR since at least September 13, 2013. The patient has had no significant functional improvement on Voltaren. Additionally, the MTUS states that there is inconsistent evidence for the use of NSAIDS to treat long term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. The Chronic Pain Medical Treatment Guidelines furthermore states that NSAIDS are recommended as an option for short-term symptomatic relief for knee and hip osteoarthritis but that they are no more effective than other medications such as acetaminophen. The ODG advises against Voltaren (Diclofenac) as a first line medication due to increased risk profile. Per the ODG, The AGS updated Beers criteria for inappropriate medication use includes diclofenac. Diclofenac is associated with a significantly increased risk of cardiovascular complications and should be removed from essential-medicines lists, according to a new review. The increased risk with diclofenac was similar to Vioxx, a drug withdrawn from worldwide markets because of cardiovascular toxicity. They recommended naproxen as the NSAID of choice. The documentation does not indicate that patient has tried other NSAIDs such as Naprosyn. The documentation does not indicate that the patient has tried Acetaminophen. The request for one prescription of Voltaren XY 100mg, thirty count, is not medically necessary or appropriate.

PRESCRIPTION OF FEXMID 7.5MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (FlexerilÂ®) Section as well as the Antispasmodics Section Page(s): 41-42,63-64.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, this medication is not recommended to be used for longer than two to three weeks. The guidelines state that Cyclobenzaprine (Fexmid) is recommended for a short course of therapy and that limited, mixed-evidence does not allow for a recommendation for chronic use. From documentation submitted patient has already been on this medication longer than the two to three week recommended period (since at least September of 2013). The request for one prescription of Fexmid 7.5mg, sixty count, is not medically necessary or appropriate.

PRESCRIPTION OF PRILOSEC 20MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Section. .

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), GI (gastrointestinal) Symptoms & Cardiovascular.

Decision rationale: There is no history that patient meets Chronic Pain Medical Treatment Guidelines for a proton pump inhibitor incuding : (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The Chronic Pain Medical Treatment Guidelines do not support treatment Proton Pump Inhibitor medication in the absence of symptoms or risk factors for gastrointestinal disorders.The request for one prescription of Prilosec 20mg, thirty count, is not medically necessary or appropriate.

2 MONTHS RENTAL FOR INTERFERENTIAL UNIT (IF) AND SUPPLIES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Teanscutaneous Electrical Nerve Stimulation (TENS) Section, as wel.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Section Page(s): 118-120.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that while an interferential unit is not recommended as an isolated intervention. The guidelines state that patient selection criteria for a one month trial may be appropriate if Interferential stimulation is to be used and include certain criteria including that the unit is effective as directed or applied by the physician or a provider licensed to provide physical medicine on patients who have a history of substance abuse, postoperative pain and are unresponsive to conservative measures. The one month trial should show evidence of less pain, increased functional improvement and medication reduction. The documentation does not reveal that the patient has had interferential stimulation applied by a physician or provider licensed to provide physical medicine or if it has been effective . The documentation does not reveal that the patient is unresponsive to conservative measures as the recent documentation indicates patient is receiving physical therapy. The documentation does not reveal that the patient has substance abuse or has had a recent surgery and is using this postoperatively. The Chronic Pain Medical Treatment Guidelines also does not recommended this treatment as an isolated intervention. Furthermore the Chronic Pain Medical Treatment guidelines state that there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The documentation does not indicate that this interferential unit is being used with an ongoing treatment plan such as exercise or return to work. The Chronic Pain Medical Treatment Guidelines also do not recommend more than a one month trial and only after patient has met the required criteria. The request for a two month rental for an IF unit with supplies is not medically necessary or appropriate.