

<b>Case Number:</b>	CM13-0063139		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	11/29/2009
<b>Decision Date:</b>	04/18/2014	<b>UR Denial Date:</b>	11/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2013

### 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 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 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 23-year-old female who reported an injury on 11/29/2009. The patient was reportedly injured when she was struck in the right knee by a pallet. The patient also twisted her right ankle and struck her back on another pallet behind her. The patient is currently diagnosed with neck sprain, brachial neuritis or radiculitis, lumbar disc protrusion, lumbar radiculopathy, right knee chondromalacia patella and right knee medial meniscal tear. The patient was seen by [REDACTED] on 11/01/2013. The patient reported persistent neck pain with radiation to bilateral upper extremities. The patient also reported constant lower back pain with radiation to bilateral lower extremities and 8/10 knee pain. Physical examination revealed decreased range of motion of the cervical and lumbar spine, positive straight leg raising on the right, decreased range of motion of the right knee with crepitus, tenderness to the medial joint line, and decreased sensation. Treatment recommendations included continuation of current medication as well as extracorporeal shock wave therapy for the right knee.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**OMEPRAZOLE 20 MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. As per the documentation submitted, there is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, the request is non-certified.

**TEROCIN PAIN PATCHES #20:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report high levels of pain. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

**ONDESTRON 4MG #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Antiemetics

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Ondansetron, Antiemetic.

**Decision rationale:** Official Disability Guidelines state Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron has been FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. The patient does not appear to meet criteria for the requested medication. As such, the request is non-certified.

**VICODIN 5/500MG #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report high levels of pain over multiple areas of the body. Satisfactory response to treatment has not been indicated. Therefore, the request is non-certified.

**FLURBI CREAM 180G #1 I:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The only FDA approved topical NSAID is diclofenac. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report high levels of pain. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

**GABACYCLOTRAM TOPICAL 180G #1:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Gabapentin is not recommended, as there is no evidence for the use of an antiepilepsy drug as a topical product. Muscle relaxants are not recommended, as there is no evidence for the use of a muscle relaxant as a topical product. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

**GENICIN CAPS #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

**Decision rationale:** California MTUS Guidelines state glucosamine is recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. As per the documentation submitted, the patient does not maintain a diagnosis of osteoarthritis. Additionally, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report 9/10 pain in the right knee. Based on the clinical information received, the request is non-certified.

**SOMNICIN CAPS #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Melatonin.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

**Decision rationale:** Official Disability Guidelines state insomnia treatment is recommended based on etiology. Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, there is no indication of functional improvement. There is also no documentation of a failure to respond to nonpharmacologic treatment prior to the initiation of a prescription product. Based on the clinical information received, the request is non-certified.

**UA (URINE ANALYSIS) FOLLOW UP (FU) VISIT EVERY 4-6 WEEKS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, screening for risk of addiction (tests)..

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341, Chronic Pain Treatment Guidelines Page(s): 43,47, & 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Urine Drug Testing.

**Decision rationale:** California MTUS Guidelines state drug testing is recommended as an option using a urine drug screen to assess for the use or presence of illegal drugs. Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification, including the use of a testing instrument. As per the documentation submitted, the patient's injury was greater than 4 years ago to date, and there is no indication of noncompliance or misuse of medication. There is also no indication that this patient falls under a high risk category that would require frequent monitoring. Therefore, the medical necessity has not been established. Additionally, California MTUS/ACOEM Practice

Guidelines state, physician follow-up is appropriate when a release to modified, increased, or full duty is needed, or after appreciable healing or recovery can be expected. The patient does maintain diagnoses of lumbar disc protrusion and lumbar radiculopathy. The patient does continue to report persistent pain. While an additional follow-up visit may be appropriate, the current request for ongoing follow-up visits every 4 to 6 weeks cannot be determined as medically appropriate. The frequency of follow-up visits should be determined by the results of the patient's condition. Based on the clinical information received, the request is non-certified.