

Case Number:	CM14-0002135		
Date Assigned:	01/24/2014	Date of Injury:	10/15/2007
Decision Date:	06/19/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/07/2014

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 Management 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 patient is a [REDACTED] employee who has filed a claim for neck sprain and strain, cervical spondylosis, lumbar intervertebral disc disorder, thoracic or lumbosacral neuritis or radiculitis, and partial tear of left supraspinatus associated with an industrial injury of October 15, 2007. Thus far, the patient has been treated with Non-Steroidal Anti-Inflammatory Drugs (NSAID), opioids, Zofran, Toradol injection, Lidoderm patch, Voltaren patch, Thermacare aquatic therapy, left shoulder arthroscopy in 2009, physical therapy to the left shoulder and low back, home exercise program, ionophoresis for the left shoulder, and lumbar epidural steroid injections. Patient has had bilateral shoulder repair. Current medications include ranitidine, Voltaren gel, Thermacare patch, Neurontin, Lidoderm patch, Vimovo, and Intermezzo. Review of progress notes reports low back pain radiating to the posterior leg, more on the right, and recent development of episodes of numbness into the left groin area. There is also burning pain on the top and bottom of the feet. Findings include decreased cervical, lumbar, and left shoulder range of motion; tenderness of the left shoulder and left cervical, thoracic, and lumbar regions; positive lumbar facet loading on the left; and positive empty can sign of the left shoulder. Patient also complains of poor sleep. Left shoulder MRI dated July 10, 2013 showed post-surgical changes; tiny region of articular-sided fraying of the distal supraspinatus tendon; diminutive anterosuperior labrum with frayed tissue; and contrast inhibition between the superior glenoid and the labrum, either normal variant or superior labral tear. Utilization review dated December 27, 2013 indicates that the claims administrator denied a request for Thermacare Patch as there is no note of efficacy with use; Lidoderm patch as patient had been restarted on Gabapentin; vimovo as there is no documentation regarding a trial of Omeprazole or Lansoprazole; Intermezzo as there is still note of poor quality sleep with this medication; Oxycodone as a recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to

fulfill any key outcome goals; and Zofran as it is not indicated for nausea associated with chronic opioid therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

THERMACARE PATCH: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/Heat Packs.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. ODG Low Back Chapter states that cold/hot packs are recommended as an option for acute pain. Patient has been on this medication since April 2013. This patient does not present with episodes of acute pain. Also, the requested quantity is not specified. Therefore, the request for thermacare patch was not medically necessary per the guideline recommendations of ODG.

LIDODERM PATCH: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 117-118 Page(s).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES , , 56-57 Page(s): 56-57.

Decision rationale: As stated on pages 56-57 in the CA MTUS chronic pain medical treatment guidelines, Lidoderm may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. Patient has been on this medication since November 2012, which was discontinued in May 2013, and restarted in August 2013. There is note that patient experiences stomach upset with use of Gabapentin, and patient was not able to tolerate Gabapentin upon re-initiation. However, there is no documentation regarding trial and failure of other first-line medications, including Serotonin-norepinephrine reuptake inhibitors (SNRI). The requested quantity is also not specified. Therefore, the request for Lidoderm patch was not medically necessary per the guideline recommendations of CA MTUS.

OXYCODONE 5 MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 82-88.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 76-78.

Decision rationale: According to CA MTUS Chronic Pain Medical Treatment Guidelines, a therapeutic trial of opioids is recommended in patients who have failed a trial of non-opioid analgesics. There should be set goals with continued use of opioids contingent on meeting these goals, baseline pain and functional assessments (including social, physical, psychological), and a pain agreement. For intermittent pain, a short-acting opioid is recommended. For continuous pain, extended-release opioids are recommended, with or without a dose of rescue opioids. In this case, there is no documentation regarding failure of non-opioid analgesics, baseline pain and functional assessments, or a pain agreement to support the use of this medication at this time. Also, the requested quantity is not specified. Therefore, the request for oxycodone was not medically necessary per the guideline recommendations of CA MTUS.

ZOFRAN 4 MG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Ondansetron)

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, FDA was used instead. The U. S. FDA recommends the use of ondansetron for prevention of nausea and vomiting caused by cancer chemotherapy, radiation therapy, and surgery. There are no recent reports regarding nausea in this patient, especially relating to chemotherapy, radiation therapy, or surgery, that would provide an indication for the use of this medication. The requested quantity is not specified. Therefore, the request for Zofran 4mg was not medically necessary per the guideline recommendations of FDA.

VIMOVO 500/20MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Non-Steroidal Anti-Infl.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 67-69.

Decision rationale: Vimovo is composed of naproxen and esomeprazole magnesium. As stated in pages 67-69 of the California MTUS chronic pain medical treatment guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and there is no evidence of long-term effectiveness for pain or function. According to page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, proton pump inhibitors are used in patients on NSAID therapy who are at risk for GI events. Risk factors includes age > 65; history

of peptic ulcer, GI bleed, or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; and high dose or multiple NSAID use. Use of PPI > 1 year has been shown to increase the risk of hip fracture. Patient has been on this medication since October 2013. Patient has a past diagnosis of GERD. Although NSAIDs is a reasonable option for pain control in this patient, there is no documentation of recent adverse gastrointestinal symptoms in this patient or risk factors as listed above. In addition, patient is already on ranitidine and there is no rationale for an additional agent such as a proton pump inhibitor. The requested quantity is not specified. Therefore, the request for Vimovo 500/20mg was not medically necessary per the guideline recommendations of CA MTUS.

INTERMEZZO 1.75: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: drugs.com: Intermezzo.

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

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, zolpidem is approved for the short-term (usually two to six weeks) treatment of insomnia. They may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. Patient has been on Ambien since November 2012, and this medication since October 2013. There is documentation that patient complains of poor sleep, but no description as to the sleep disturbance or the quality and quantity of sleep. Also, this medication is not recommended for long-term use. There is no documentation of improvement in sleep with this medication. In addition, the requested quantity is not specified. Therefore, the request for Intermezzo was not medically necessary per the guideline recommendations of ODG.