

Case Number:	CM14-0004861		
Date Assigned:	01/24/2014	Date of Injury:	12/21/2010
Decision Date:	06/20/2014	UR Denial Date:	12/20/2013
Priority:	Standard	Application Received:	01/10/2014

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 Physical Medicine & 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 58 year old male with a work injury dated 12/21/10. The diagnoses include lumbar radiculopathy, thoracic spine strain, left shoulder impingement syndrome. There are requests for retrospective for Hydrocodone (Norco)APAP 10/325mg #120 DOS 12/5/13; Omeprazole DR 20mg #30 DOS: 12/5/13; Orphenadrine ER 100mg #60 DOS: 12/5/13 and Volteran 1% Gel. He has had treatment that has included multiple sessions of physical therapy, acupuncture and medication management. He is currently temporarily totally disabled. A 1/9/14 office note states that the patient is undergoing acupuncture treatment which is helping his symptoms. The patient's back pain, however, does persist but he notices some alleviation with the acupuncture. The patient continues to take medications for pain. The left shoulder reveals range of motion on flexion and abduction is decreased. Impingement sign is positive. Anterior shoulder is tender to palpation. The thoracic spine reveals that paraspinal muscles are tender. Spasm is present. The lumbar spine reveals that paraspinal muscles are tender. Spasm is present. Range of motion is restricted. Deep tendon reflexes are normal and symmetrical. Sensation is reduced in the right L5 dermatomal distribution. Straight leg raising test is positive on the right.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR HYDROCODONE (NORCO) APAP 10/325MG #120 DOS: 12/5/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS, 80

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Opioids, criteria for use Page(s): 76-80.

Decision rationale: The request for retrospective for Hydrocodone (Norco)APAP 10/325mg #120 DOS 12/5/13 is not medically necessary. The documentation submitted is not clear on patient's ongoing review and documentation of pain relief, functional status and on-going medication management or treatment plan. This would include appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. There is no indication that the pain has improved patient's pain or functioning to a significant degree therefore Hydrocodone is not medically necessary. The MTUS guidelines state to discontinue opioids if there is no overall improvement in function and to continue opioids if the patient has returned to work or has the patient has improved functioning and pain. The documentation submitted reveals no evidence of functional improvement therefore the request for retrospective for Hydrocodone (Norco)APAP 10/325mg #120 DOS 12/5/13 is not medically necessary.

RETROSPECTIVE REQUEST FOR OMEPRAZOLE DR 20MG #30 DOS: 12/5/13:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK, 69

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: The request for Omeprazole DR 20mg #30 DOS: 12/5/13 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. There is no history that patient meets MTUS criteria for a proton pump inhibitor including : (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). There is no evidence of dyspepsia from NSAID use. The California Medical Treatment Utilization Schedule Chronic Pain Guidelines do not support treatment Proton Pump Inhibitor medication in the absence of symptoms or risk factors for gastrointestinal disorders. The request for Omeprazole DR 20mg #30 DOS 12/5/13 is not medically necessary.

RETROSPECTIVE REQUEST FOR ORPHENADRINE ER 100MG #60 DOS: 12/5/13:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, MUSCLE RELAXANTS (FOR PAIN), 63

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Muscle relaxants Page(s): 63-65.

Decision rationale: The request for retrospective Orphenadrine ER 100mg #60 DOS: 12/5/13 is not medically necessary per the MTUS guidelines. Orphenadrine is a muscle relaxant. The MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. The documentation indicates that the patient has been on this medication dating back to at least 2012. The documentation does not indicate functional improvement on this medication which is not meant to be used long term. The request for retrospective Orphenadrine ER 100mg #60 DOS 12/5/13 is not medically necessary

RETROSPECTIVE REQUEST FOR VOLTAREN 1% GEL DOS: 12/5/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, 112

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

Decision rationale: The request for Voltaren Gel 1% DOS 12/5/13 is not medically necessary per the MTUS guidelines. The guidelines state that Voltaren Gel 1% (diclofenac) 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 that the patient has chronic low back pain. There is no documentation of osteoarthritis in the joints that lend themselves to topical treatment as noted for Voltaren. The request for Voltaren Gel 1% DOS 12/5/13 is not medically necessary.