MAXIMUS Federal Services

Case Number:	CM14-0100668		
Date Assigned:	08/29/2014	Date of Injury:	07/24/2006
Decision Date:	10/20/2014	UR Denial Date:	06/10/2014
Priority:	Standard	Application Received:	06/30/2014

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 Occupational Medicine 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:

There were 84 pages provided for this review. The claimant's attorney signed the application on June 25, 2014. The issue for this review was hydrocodone APAP number 240. Several other medicines were addressed as well. The review was done on June 10, 2014. Per the records provided, this claimant was injured in 2006. She had a lumbar strain, lumbosacral disc degeneration, lumbar disc displacement, lumbago and lumbosacral neuritis. The claimant had a colostomy reversal on March 30, 2014 and was healing well. On November 18, the claimant had a lumbar MRI that showed a 2 mm central protrusion at L4-L5 with subtle annular fissuring, and mild facet hypertrophic changes. As of February 19, 2014, the claimant presented with complaints of neck pain, headaches, low back pain and leg pain. The pain gets to the 10 out of 10 level. It affects both sides of the head and comes from her neck pain. The Pennsaid drops that she uses on her neck and into the hairline have helped this pain. She has a TENS unit but needs supplies for it. The epidural done on March 13 helped her a great deal with 80% relief and she was able to perform activities of daily living and take less medicine for a while. The current medicines are tramadol, Norco, Pennsaid, Flector patch, Lidoderm, Neurontin, and Colace. The physical examination showed tenderness and tightness over the posterior cervical area and bilateral trapezius and scapular with about 50% restriction in flexion and extension. A negative Spurling sign was noted. The lumbar spine exam noted tenderness and tightness across the lumbosacral area with 30% restriction of flexion and 50% with extension and lateral bending. A positive straight leg raise bilaterally was noted, left greater than the right. There is some hypoesthesia and dysesthesia in the posterior thighs and calves. The claimant's motor strength was five out of five in all major muscle groups. Deep tendon reflexes are noted as one plus bilaterally in the upper and lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pennsaid 1.5 MG with 3 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. Page(s): 67 of 127.

Decision rationale: The MTUS recommends non-steroidal anti-inflammatory drugs (NSAID) medication like Pennsaid for osteoarthritis, at the lowest does, and the shortest period possible. The use here appears chronic, with little information in regards to functional objective improvement out of the use of the prescription NSAID. Further, the guides cite that there is no reason to recommend one drug in this class over another based on efficacy. It is not clear why a prescription variety of NSAID would be necessary; therefore, when over the counter NSAIDs would be sufficient. In summary, the MTUS cites there is no evidence of long-term effectiveness for pain or function. This claimant though has been on some form of a prescription non-steroidal anti-inflammatory medicine for some time, with no documented objective benefit or functional improvement. The MTUS guideline of the shortest possible period of use is clearly not met. Without evidence of objective, functional benefit, such as improved work ability, improved activities of daily living, or other medicine reduction, the MTUS does not support the use of this medicine. Pennsaid 1.5 MG with 3 Refills is not medically necessary.

Flector Patch 1.3% with 3 Refills: Upheld

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

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

Decision rationale: Regarding Flector patches, the ODG notes in the pain section that it is not recommended as a first-line treatment. It is not clear what other agents had been exhausted before moving to this patch. Further, the Flector patch is FDA indicated for acute strains, sprains, and contusions. (FDA, 2007) It is not for chronic issues. The significant side effects noted in the 12/07/09 the FDA warnings, are not addressed. It is not clear this risk has been addressed in this case with measurements of transaminases periodically in patients receiving long-term therapy with diclofenac. Also, the benefit of topical NSAIDS is good for about two weeks, and studies are silent on longer term usage, therefore a long term usage as in this case is not supported. There simply is no data that substantiate Flector efficacy beyond two weeks. The Flector Patch 1.3% with 3 Refills is not medically necessary.

Tramadol 50 MG #240 with 3 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain interventions and treatments 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 200.

Decision rationale: Per the MTUS, Tramadol is an opiate analogue medication, not recommended as a first-line therapy. The MTUS based on Cochrane studies found very small pain improvements, and adverse events caused participants to discontinue the medicine. Most important, there are no long term studies to allow it to be recommended for use past six months. Tramadol 50 MG #240 with 3 Refills is not medically necessary.

Lidoderm Patch 5% #60 with 3 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 56 of 127.

Decision rationale: Lidoderm is the brand name for a lidocaine patch produced by [redacted]. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. It is not clear the patient had forms of neuralgia, and that other agents had been first used and exhausted. The MTUS notes that further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Lidoderm Patch 5% #60 with 3 Refills is not medically necessary.

Ondasetron 8 MG 330 with 3 Refills: 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 Anti Emetics for Opioid Nausea

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

Decision rationale: The MTUS was silent on this medicine. The ODG notes Ondansetron (Zofran): This drug is a serotonin 5-HT3 receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. Acute use is FDA-approved for gastroenteritis. It is not recommended for nausea and vomiting secondary to chronic opioid use. It is recommended for acute use per FDA-approved indications. This is a special anti-emetic for special clinical circumstances; those

criteria are not met in this injury case. Ondansetron 8 MG 330 with 3 Refills is not medically necessary.