

Case Number:	CM14-0010293		
Date Assigned:	02/21/2014	Date of Injury:	09/07/2006
Decision Date:	06/30/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	01/24/2014

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 and Rehabilitation, 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:

This is a patient with a date of injury of 9/7/06. A utilization review determination dated 1/21/14 recommends non-certification of Protonix, Voltaren XR, Ultram, and Terocin. Norco was modified from #60 and 3 refills to #30 for tapering. 1/13/14 medical report identifies continued left knee pain with activity. On exam, no abnormal findings are noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

PROTONIX 20 MG #60 REFILL X 3: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

Decision rationale: Regarding the request for Pantoprazole (Protonix), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Additionally, ODG recommends Nexium, Protonix, Dexilant, and AcipHex for use as 2nd line agents, after failure of Omeprazole or Lansoprazole. Within the documentation available for review, there is no

indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. Furthermore, there is no indication that the patient has failed first-line agents prior to initiating treatment with Pantoprazole (a 2nd line proton pump inhibitor). In the absence of clarity regarding those issues, the currently requested Pantoprazole is not medically necessary.

VOLTAREN XR 100 MG #60 REFILL X 3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: Regarding the request for Voltaren (Diclofenac), Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Voltaren is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Voltaren is not medically necessary.

NORCO 10/325 MG #60 REFILL X 3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79.

Decision rationale: Regarding the request for Norco (Hydrocodone/Acetaminophen), California Pain Medical Treatment Guidelines state that Norco is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the Norco is improving the patient's function or pain (in terms of percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. Unfortunately, there is no provision to modify the current request to allow tapering. In the absence of such documentation, the currently requested Norco is not medically necessary.

ULTRAM 50MG #60 REFILL X 3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75-79.

Decision rationale: Regarding the request for Ultram, California Pain Medical Treatment Guidelines state that Ultram is a short acting opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the Ultram is improving the patient's function (in terms of specific objective functional improvement) or pain (in terms of reduced NRS, or percent reduction in pain), no documentation regarding side effects, and no discussion regarding aberrant use. In the absence of such documentation, the currently requested Ultram is not medically necessary.

TEROCIN 120 ML #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 71.

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

Decision rationale: Regarding the request for Terocin, California MTUS cites that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Topical Lidocaine is "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 Labapentin or Lyrica)." Additionally, it is supported only as a dermal patch. Capsaicin is "Recommended only as an option in patients who have not responded or are intolerant to other treatments." None of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. In light of the above issues, the currently requested Terocin is not medically necessary.