

<b>Case Number:</b>	CM14-0111620		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	11/02/2002
<b>Decision Date:</b>	10/02/2014	<b>UR Denial Date:</b>	06/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2014

### 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 11/2/02. A utilization review determination dated 6/26/14 recommends non-certification of hydrocodone, Voltaren gel, and lansoprazole. 6/9/14 medical report identifies low back pain. He has pain with activity and needs a cane for ambulation. He also has some more foot and toe pain. On exam, there is lumbar tenderness and spasm as well as decreased range of motion (ROM) of the lumbar spine and right ankle. There is give way weakness in all muscle groups of the bilateral lower extremity (BLE) with 3/5 strength in the right ankle. He has been taking pain medications via liquid as prescribed. He needs his medications. He has a history of gastric bypass. Recommendations include Lorcet liquid 7.5/325 per 15 cc, 15 ml po qid #1800 ml, Lyrica, Prevacid, and Voltaren gel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydroco/APAP SOL 7.5/325, 30 day supply Qty: 1800:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79, 120 of 127.

**Decision rationale:** Regarding the request for hydrocodone, California Pain Medical Treatment Guidelines state that, 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 medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. In light of the above issues, the currently requested hydrocodone is not medically necessary.

**Voltaren Gel 1% ,25 day supply Qty: 100: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** Regarding the request for Voltaren gel, CA MTUS states that topical non-steroidal anti-inflammatory drugs (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." Within the documentation available for review, none of the abovementioned criteria have been documented and there is no clear indication of significant efficacy with prior use such as improved pain scores, examples of functional improvement, etc. In light of the above issues, the currently requested Voltaren gel is not medically necessary.

**Lansoprazole 30 mg DR ,30 day supply Qty: 30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69 of 127.

**Decision rationale:** Regarding the request for lansoprazole, 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. Within the documentation available for review, it is noted that the patient has a history of gastric bypass, but the NSAID and other oral medications have been determined not to be medically necessary and there is no other clear indication for the medication presented. In light of the above issues, the currently requested lansoprazole is not medically necessary.