

Case Number:	CM14-0111844		
Date Assigned:	08/01/2014	Date of Injury:	01/12/2005
Decision Date:	10/09/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	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 and is licensed to practice in Texas and Ohio. 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 injured worker is a 63-year-old female who reported an injury on 01/12/2005 due to an unknown mechanism. Diagnoses were chronic pain syndrome, rotator cuff syndrome, and anxiety state (not otherwise specified). Past treatments were acupuncture, massage, and aqua therapy. Diagnostic studies were not reported. Surgical history was not reported. The physical examination on 06/19/2014 revealed no signs of external trauma, ecchymosis, lacerations, abrasions, or hematoma of the cervical spine. Palpation to the cervical spine revealed paravertebral muscles were tender and spasm was present. The sensory examination revealed no deficits to pinprick or light touch in any of the dermatomes of the upper extremities. The motor strength was normal. The treatment plan was to continue medications as directed along with requesting acupuncture. Medications were Orphenadrine ER 100mg twice a day, Omeprazole 20mg daily, Voltaren 1% gel applied twice a day, Hydrocodone 5/325mg twice a day, and Lidoderm 5% patch applied every 12 hours. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine ER 100 mg #60 with 2 refills: Upheld

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

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

Decision rationale: The request for Orphenadrine ER 100mg, quantity of 60, with 2 refills is not medically necessary. The California Medical Treatment Utilization Schedule guidelines recommend muscle relaxants as a second-line option for the short-term treatment of acute low back pain, and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time, and there was a lack of documentation of objective improvement. Therefore, continued use of this medication would not be supported. Therefore, this request is not medically necessary.

Omeprazole DR 20mg #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

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

Decision rationale: The request for Omeprazole DR 20mg #30 with 2 refills is not medically necessary. Guidelines indicate that clinicians should determine if the patient is at risk for gastrointestinal events. Risk factors include: age greater than 65 years; a history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA (Aspirin), corticosteroids, and/or an anticoagulant; or use of a high dose/multiple NSAIDs. For patients with no risk factor and no cardiovascular disease, non-selective NSAIDs are okay (e.g., Ibuprofen, Naproxen, etc.) For patients at intermediate risk for gastrointestinal events and no cardiovascular disease, the guidelines recommend one of the following: a non-selective NSAID with either a proton pump inhibitor (PPI), such as Omeprazole, or Misoprostol; or a Cox-2 selective agent. Long-term PPI use (greater than 1 year) has been shown to increase the risk of hip fracture. For patients at high risk for gastrointestinal events with no cardiovascular disease, guidelines indicate a Cox-2 selective agent plus a PPI if absolutely necessary. The efficacy of this medication for this patient was not reported. It was not reported that injured worker was having gastrointestinal events. The request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Voltaren 1% Gel: 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 Topical Analgesics and Diclofenac Page(s): 111 and 71.

Decision rationale: The request for Voltaren 1% gel is not medically necessary. The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely

experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Voltaren 1% (Diclofenac) is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. It was not reported that the injured worker had osteoarthritis. The efficacy of this medication for this patient was not reported. The request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Norco 5/325mg #60 with 6 refills: 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 Norco and Ongoing Management Page(s): 75 and 78.

Decision rationale: The request for Norco 5/325mg #60 with 6 refills is not medically necessary. The California Chronic Pain Medical Treatment Guidelines recommend short-acting opioids such as Norco for controlling chronic pain. For ongoing management, there should be documentation of the 4 A's (including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The documentation submitted for review does not document the 4 A's of ongoing monitoring for Norco for this patient. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Lidoderm Patch 5% #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 Topical Analgesics and Lidocaine Page(s): 111-112.

Decision rationale: The request for Lidoderm patch 5% #30 is not medically necessary. The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (a tricyclic or SNRI antidepressant or an AED such as Gabapentin or Lyrica). No other commercially-approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

