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| Case Number: | CM14-0152342 | | |
| Date Assigned: | 09/22/2014 | Date of Injury: | 06/28/2005 |
| Decision Date: | 10/21/2014 | UR Denial Date: | 09/10/2014 |
| Priority: | Standard | Application Received: | 09/18/2014 |

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 Anesthesiology, 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:

According to the records made available for review, this is a 53-year-old male with a 6/28/05 date of injury. At the time (9/10/14) of the Decision for 60 Voltaren-XR 100mg (through express scripts 800-945-5951), 60 Hydro/apap 7.5 mg (through express scripts 800-945-5951), 180 Hydro/apap 10/325mg (through express scripts 800-945-5951), 60 Soma 350mg (through [REDACTED]), 1 Prescription for flurbiprofen 30gm (through e [REDACTED]), 1 Prescription for flurbiprofen 120gm (through [REDACTED]), there is documentation of subjective (constant low back pain, numbness and tingling radiating down the left lower extremity, pain rated 9/10) and objective (limited lumbosacral flexion and extension, paravertebral muscle tenderness with spasm, decreased sensation to the left lower extremity, pain with straight leg raise) findings, current diagnoses (lumbar spine spondylosis), and treatment to date (activity modification and medications (including ongoing use of Voltaren, hydrocodone/APAP, Soma, and flurbiprofen since at least 10/13)). 8/25/14 medical report identifies that medications helped reduce the symptoms by 35%. Regarding the requested 60 Voltaren-XR 100mg (through express scripts 800-945-5951), there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Voltaren use to date. Regarding the requested 60 Hydro/apap 7.5 mg (through [REDACTED]) and 180 Hydro/apap 10/325mg (through [REDACTED]), there is no documentation that the prescriptions are from a single practitioner and are taken as directed; that the lowest possible dose is being prescribed; and that there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of hydrocodone/APAP use to date. Regarding the

requested 60 Soma 350mg (through [REDACTED]), there is no documentation of an acute exacerbation of chronic low back pain and that Soma is being used as a second line option; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Soma use to date. Regarding the requested 1 Prescription for flurbiprofen 30gm (through [REDACTED]), and 1 Prescription for flurbiprofen 120gm (through [REDACTED]), there is no documentation that trials of antidepressants and anticonvulsants have failed.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 Voltaren-XR 100mg (through express scripts 800-945-5951): 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 NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnosis of lumbar spine spondylosis. In addition, there is documentation of chronic low back pain. However, given medical records reflecting prescription for Voltaren since at least 10/13, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Voltaren use to date. Therefore, based on guidelines and a review of the evidence, the request for 60 Voltaren-XR 100mg (through [REDACTED]) is not medically necessary.

60 Hydro/apap 7.5 mg (through [REDACTED]): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the

lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnosis of lumbar spine spondylosis. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; that the lowest possible dose is being prescribed; and that there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given medical records reflecting prescription for hydrocodone/APAP since at least 10/13, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of hydrocodone/APAP use to date. Therefore, based on guidelines and a review of the evidence, the request for 60 Hydro/apap 7.5 mg (through [REDACTED]) is not medically necessary.

180 Hydro/apap 10/325mg (through [REDACTED]): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnosis of lumbar spine spondylosis. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; that the lowest possible dose is being prescribed; and that there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given medical records reflecting prescription for hydrocodone/APAP since at least 10/13, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of hydrocodone/APAP use to date. Therefore, based on guidelines and a review of the evidence, the request for 180 Hydro/apap 10/325mg (through [REDACTED]) is not medically necessary.

60 Soma 350mg (through [REDACTED]): 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 (for pain) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended for short-term (less than two weeks) treatment. Within the medical information available for review, there is documentation of diagnosis of lumbar spine spondylosis. However, there is no documentation of an acute exacerbation of chronic low back pain and that Soma is being used as a second line option. In addition, given medical records reflecting prescription for Soma since at least 10/13, there is no documentation of an intention for short-term treatment. Furthermore, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Soma use to date. Therefore, based on guidelines and a review of the evidence, the request for Soma 350mg (through [REDACTED]) is not medically necessary.

1 Prescription for flurbiprofen 30gm (through [REDACTED]): 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 Topical Analgesics Page(s): 111.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Within the medical information available for review, there is documentation of diagnosis of lumbar spine spondylosis. In addition, there is documentation of neuropathic pain. However, there is no documentation that trials of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request for 1 Prescription for flurbiprofen 30gm (through [REDACTED]) is not medically necessary.

1 Prescription for flurbiprofen 120gm (through [REDACTED]): 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 Topical Analgesics Page(s): 111.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Within the medical information available for review, there is documentation of diagnosis of lumbar spine spondylosis. In addition, there is documentation of neuropathic pain. However, there is no documentation that trials of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request for 1 Prescription for flurbiprofen 120gm (through [REDACTED]) is not medically necessary.