

<b>Case Number:</b>	CM14-0030188		
<b>Date Assigned:</b>	03/19/2014	<b>Date of Injury:</b>	08/25/2010
<b>Decision Date:</b>	04/22/2014	<b>UR Denial Date:</b>	02/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2014

### 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, Pain Management and is licensed to practice in Florida. 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 patient reported an injury on 08/25/2010 due to cumulative trauma while performing normal job duties. The patient's most recent clinical evaluation documented that the patient had tenderness to palpation along the paravertebral musculature with spasming and restricted range of motion. The patient had a positive straight leg raising test to the right and reduced sensation in the right S1 dermatomal distribution. The patient's diagnoses included lumbar radiculopathy and anxiety reaction. The patient's treatment plan included aquatic therapy and continuation of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HYDROCODONE10/325MG 360:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Goint Management Page(s): 78.

**Decision rationale:** The requested hydrocodone 10/325 mg 360 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of opioids in the management of chronic pain be supported by documentation of a quantitative assessment

of pain relief, increased functional capabilities, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review failed to provide any evidence the patient is monitored for aberrant behavior. Additionally, there is no documentation of increased functional benefit or a quantitative assessment of pain relief to support the efficacy of this medication. Therefore, continued use would not be supported. As such, the requested hydrocodone 10/325 mg 360 is not medically necessary or appropriate.

**KETOPROFEN 75MG #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

**Decision rationale:** The requested Ketoprofen 75 mg #30 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of non-steroidal anti-inflammatory drugs in the management of chronic pain. However, California Medical Treatment Utilization Schedule recommends that continued use of medications in the management of chronic pain be supported by documentation of functional benefit and an assessment of pain relief. The clinical documentation submitted for review fails to provide any evidence that the patient receives any pain relief or a significant increase in functional benefit as a result of the patient's medication usage. Therefore, continued use would not be supported. As such, the requested Ketoprofen 75 mg #30 is not medically necessary or appropriate.

**OMEPRAZOLE 20MG #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs GI Symptoms & Cardiovascular Risk Page(s): 68.

**Decision rationale:** The requested Omeprazole 20 mg #30 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of gastrointestinal protectants for patients who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to support that they are at risk for developing gastrointestinal events related to medication usage. Therefore, continued use of this medication would not be supported. As such, the requested Omeprazole 20 mg #30 is not medically necessary or appropriate.

**CARISOPRODOL 350MG #60:** Upheld

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

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

**Decision rationale:** The requested Carisoprodol 350 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the long-term use of this medication in the management of moderate to severe chronic pain. California Medical Treatment Utilization Schedule recommends a limited duration of treatment of up to 2 to 3 weeks. The clinical documentation submitted for review indicates that this patient has been on this medication since at least 07/2013. As the patient has already exceeded guideline recommendations and there are no exceptional factors to support extending treatment beyond guideline recommendations, continued use of this medication would not be supported. As such, the requested Carisoprodol 350 mg #60 is not medically necessary or appropriate.

**MEDROX OINTMENT:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The requested Medrox ointment is not medically necessary or appropriate. The requested medication is a compounded topical agent that contains menthol, methyl salicylate, and capsaicin. California Medical Treatment Utilization Schedule recommends the use of menthol and methyl salicylate for patients who have osteoarthritic related pain. The clinical documentation does not provide any evidence that the patient's pain is osteoarthritic in nature. Additionally, the requested medication contains capsaicin. California Medical Treatment Utilization Schedule does not recommend the use of capsaicin as a topical agent unless all other first line chronic pain management modalities have been exhausted. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to other first line oral analgesics to include antidepressants and anticonvulsants. As such, the requested Medrox ointment is not medically necessary or appropriate.