

<b>Case Number:</b>	CM14-0045513		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	10/03/2003
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	03/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2014

### 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 Internal Medicine and is licensed to practice in Arizona. 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 57-year-old female with a date of injury on October 3, 2003 with reported subsequent falls causing worsening symptomatology. She has had injury to her left shoulder and is now status post subacromial decompression. She additionally has cervical degenerative disc disease with multilevel spinal stenosis, right carpal tunnel syndrome, probable left ulnar nerve irritation at the wrist and multilevel lumbar degenerative disc disease. She reports good days and bad days. Her primary complaints have been her neck, her lower back with occasional radiation to the lower extremity, and her right forearm. She additionally has reported hand pain and numbness, especially at night that awakens her. Her medications include Voltaren 75 mg twice a day, Tylenol No. 3 twice a day. On January 8, 2014 the claimant expressed concerns about having epigastric pain with her Voltaren. Prilosec 20 mg was added to her regimen. There is no discussion of this patient having any history of peptic ulcer disease. It was commented that the patient reports functional improvement and pain relief with her medications. On July 2, 2014, after both her Voltaren and Prilosec were found not medically necessary, the progress note documents that the patient has acute exacerbations which she sometimes is inadequately controlled with her current medications; other times she does benefit from the Voltaren, getting functional improvement and pain relief. For the acute exacerbations not adequately managed with Voltaren and Tylenol 3, a compounded medication containing lidocaine and Flurbiprofen was prescribed. There is no indication if the patient has ever had a trial of a Tricyclic or SNRI antidepressant, or an anti-epileptic in an effort to help with the chronic pain. The purpose of this Independent Medical Review is to determine if both Voltaren and Prilosec are deemed medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prospective request for 1 prescription of Voltaren 75mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory Medications; Specific Recommendations (for NSAIDs) Page(s): 22; 67-68.

**Decision rationale:** Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. Specific recommendations: Osteoarthritis: Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. Non-steroidal anti-inflammatory drugs (NSAIDs) appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. Back pain- acute exacerbations of chronic pain: Recommended as a second line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute lumbar back pain. For patients with acute low back pain with sciatica a recent Cochran review (including 3 heterogeneous randomized control trials) found no differences in treatments with NSAIDs versus placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low back pain, and that acetaminophen had fewer side effects. The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with low back pain over that received with acetaminophen treatment and advice from their physician. Chronic low back pain Recommended as an option for short-term symptomatic relief. A Cochran review of the literature on drug relief for low back pain suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen. In addition, evidence from the review suggested that no one NSAID, including Cox 2 inhibitors, was clearly more effective than another. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) and with neuropathic pain. Besides the above well documented side effects of NSAIDs, there are other less well known effects of NSAIDs, and the use of NSAIDs has been shown to possibly delay and hamper healing and all the soft tissues, including muscles, ligaments, tendons, and cartilage. In light of the multiple diagnoses, it is clear this claimant has different types of pain including neuropathic pain (from carpal tunnel syndrome, cervical spinal stenosis & lumbar radiculopathy), nociceptive pain (lumbar myofascial pain) and chronic low back pain with reported acute exacerbations. Technically, this patient could meet the criteria for using NSAIDs, but short-term usage is recommended. Also, although it is stated she has flares in her pain, she has remained on a chronic twice/day dosing since 2003, suggesting that she is not taking Voltaren on an as needed basis. There are comments that she has functional improvement and pain relief with her medications; yet, a new prescription for compounded medication containing lidocaine and

Flurbiprofen was given to the patient to help with those poorly controlled flares. It would suggest that Voltaren does not help as much as she has stated. There is no clear justification to continue Voltaren twice/daily long term. This Reviewer believes that if the claimant has not yet had a trial of a Tricyclic or SNRI antidepressant, or an anti-epileptic; it is reasonable to undergo a trial with the goal of reducing her chronic pain to a more tolerable level. Thus, it is deemed that Voltaren 75mg, #60 is not medically necessary.

**Prospective request for 1 prescription of Prilosec 20mg #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Risk Page(s): 68.

**Decision rationale:** According to the MTUS, clinicians should weigh the indications for NSAIDs against GI risk factors and then treat accordingly. The gastrointestinal risk factors listed include: 1) Age greater than 65 years, 2) History of peptic ulcer, GI bleeding or perforation, 3) Concurrent use of aspirin, corticosteroids, and/or an anticoagulant, and 4) High dose/multiple NSAIDs. Treatment is then based on the presence of risk factors. Patients with no risk factor can be given nonselective NSAIDs. Patients at intermediate risk for gastrointestinal events should be given nonselective NSAIDs with either a PPI or misoprostol 200g 4 times daily or a Cox 2 selective agent. The MTUS, Chronic Pain Treatment Guidelines only recommend proton pump inhibitors for patients with a high or intermediate risk of GI adverse events. This patient has a low risk for GI complications, and medical records show that the patient has no history of GI bleeding or ulcers. The medical necessity of this medication has not been demonstrated; thus, Prilosec 20mg, #30 is not medically necessary.