

Case Number:	CM14-0080460		
Date Assigned:	08/08/2014	Date of Injury:	06/28/2006
Decision Date:	09/26/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	06/02/2014

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 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 female with a 6/28/06 date of injury. At the time (5/20/14) of the Decision for Ibuprofen tab 800mg day supply: 90 qty: 90 refills: 00, Voltaren Gel 1% day supply: 15 qty: 100 refills: 00, Lidocaine Pad 5% day supply: 90 qty: 90 refills: 00, Hydroco/APAP tab 10-325mg day supply: 30 qty: 120 refills: 00, Omeprazole cap 40mg day supply: 90 qty: 90 refills: 00, and Carisoprodol tab 350mg day supply: 30 qty: 30 refills:00, there is documentation of subjective (neck pain, right shoulder pain, and bilateral wrist pain) and objective (tenderness to palpation over the cervical spine, trapezius, paravertebral musculature, rhomboids and occipital muscle with spasms, hypertonicity and trigger points; right shoulder tenderness over the acromioclavicular joint, biceps groove and subdeltoid bursa; right elbow tenderness over the lateral and medial epicondyles; right wrist tenderness over the dorsal and volar creases; motor weakness of the right shoulder; decreased range of motion of the cervical spine, right shoulder and right wrist) findings, current diagnoses (chronic pain), and treatment to date (ongoing therapy with Ibuprofen, Neurontin, Zofran, Voltaren gel, Effexor, Hydrocodone/APAP, Lidocaine patch and Soma). In addition, 6/23/14 medical report identifies that the patient does not show any sign of abuse or misuse of medications, and that the current medication regimen results in decreased pain levels and increased activities of daily living. Regarding Ibuprofen tab 800mg day supply: 90 qty: 90 refills: 00, 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 the specific use of Ibuprofen. Regarding Voltaren Gel 1% day supply: 15 qty: 100 refills: 00, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (hand and wrist), an intention for short-term use (4-12 weeks), failure of an oral NSAID or contraindications to oral NSAIDs, 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 the specific use of Voltaren gel. Regarding Lidocaine Pad 5% day supply: 90 qty: 90 refills: 00, there is no documentation of neuropathic pain after there has been evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed; 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 the specific use of Lidoderm pad. Regarding Hydroco/APAP tab 10-325mg day supply: 30 qty: 120 refills: 00, there is no 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; 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 the specific use of Hydrocodone/APAP. Regarding Omeprazole cap 40mg day supply: 90 qty: 90 refills: 00, there is no documentation of risk for gastrointestinal event (high dose/multiple NSAID). Regarding Carisoprodol tab 350mg day supply: 30 qty: 30 refills: 00, there is no documentation of acute exacerbation of chronic pain, short-term (less than two weeks) treatment, 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 the specific use of Carisoprodol.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen tab 800mg day supply: 90 qty: 90 refills: 00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's (non-steroidal anti-inflammatory).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

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 a diagnosis of chronic pain. In addition, there is documentation of chronic pain and ongoing treatment with Ibuprofen. However, despite documentation of decreased pain and increased activities of daily living with current medication regimen, there is no (clear) 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 the specific use of Ibuprofen. Therefore, based on guidelines and a review of the evidence, the request for Ibuprofen tab 800mg day supply: 90 qty: 90 refills: 00 is not medically necessary.

Voltaren Gel 1% day supply: 15 qty: 100 refills: 00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Diclofenac Sodium.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of Voltaren Gel 1%. In addition, 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 documentation of failure of an oral NSAID or contraindications to oral NSAIDs, as criteria necessary to support the medical necessity of Voltaren Gel. Within the medical information available for review, there is documentation of a diagnosis of chronic pain. However, despite documentation of wrist/hand pain, there is no (clear) documentation of osteoarthritis pain in joints that lend themselves to topical treatment (hand and wrist). In addition, given documentation of ongoing treatment with Voltaren gel, there is no documentation of an intention for short-term use (4-12 weeks). Furthermore, given documentation of ongoing treatment with oral NSAID and an associated request for Ibuprofen, there is no documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Lastly, despite documentation of decreased pain and increased activities of daily living with current medication regimen, there is no (clear) 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 the specific use of Voltaren gel. Therefore, based on guidelines and a review of the evidence, the request for Voltaren Gel 1% day supply: 15 qty: 100 refills: 00 is not medically necessary.

Lidocaine Pad 5% day supply: 90 qty: 90 refills: 00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch) Page(s): 56-57.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain after there has been evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed, as criteria necessary to support the medical necessity of a lidocaine patch. 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 a diagnosis of chronic pain. In addition, there is documentation of ongoing treatment with Lidocaine pad. However, there is no documentation of neuropathic pain. In addition, given documentation of ongoing treatment with Effexor and Neurontin, there is no documentation of evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed. Furthermore, despite documentation of decreased pain and increased activities of daily living with current medication regimen, there is no (clear) 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 the specific use of Lidoderm pad. Therefore, based on guidelines and a review of the evidence, the request for Lidocaine Pad 5% day supply: 90 qty: 90 refills: 00 is not medically necessary.

Hydroco/APAP tab 10-325mg day supply: 30 qty: 120 refills: 00: 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 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 a diagnosis of chronic pain. However, despite documentation that the patient does not show any sign of abuse or misuse of medications, there is no (clear) 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. In addition, despite documentation of decreased pain and increased activities of daily living with current medication regimen, there is no (clear) 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 the specific use of Hydrocodone/APAP. Therefore, based on guidelines and a review of the evidence, the request for Hydroco/APAP tabs 10-325mg day supply: 30 qty: 120 refills: 00 is not medically necessary.

Omeprazole cap 40mg day supply: 90 qty: 90 refills: 00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's (non-steroidal anti-inflammatory).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Proton pump inhibitors (PPIs).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that risk for gastrointestinal event includes age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; and/or high dose/multiple NSAID. 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 documentation of risk for gastrointestinal events and preventing gastric ulcers induced by NSAIDs, as criteria necessary to support the medical necessity of Omeprazole. Within the medical information available for review, there is documentation of a diagnosis of chronic pain. In addition, there is documentation of chronic NSAID therapy and preventing gastric ulcers induced by NSAIDs. However, there is no documentation of risk for gastrointestinal event (high dose/multiple NSAID). Therefore, based on guidelines and a review of the evidence, the request for Omeprazole cap 40mg day supply: 90 qty: 90 refills: 00 is not medically necessary.

Carisoprodol tab 350mg day supply: 30 qty: 30 refills:00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that Carisoprodol (Soma) is not recommended and that this medication is not indicated for long term use. 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 as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of a diagnosis of chronic pain. However, there is no documentation of acute exacerbation of chronic pain. In addition, given documentation of ongoing treatment with Carisoprodol, there is no documentation of short-term (less than two weeks) treatment. Furthermore despite documentation of decreased pain and increased activities of daily living with current medication regimen, there is no (clear) 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 the specific use of Carisoprodol. Therefore, based on guidelines and a review of the evidence, the request for Carisoprodol tab 350mg day supply: 30 qty: 30 refills: 00 is not medically necessary.