

Case Number:	CM14-0126610		
Date Assigned:	09/05/2014	Date of Injury:	01/08/2010
Decision Date:	07/09/2015	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	08/11/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York
 Certification(s)/Specialty: Anesthesiology

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 52 year old male, who sustained an industrial injury on 1/8/10. He reported pain in the neck, left elbow, and low back. The injured worker was diagnosed as having right lower extremity radiculitis and status post healed L5-S1 fusion. Treatment to date has included transforaminal lumbar interbody fusion at L5-S1, revision fusion at L5-S1, lumbar epidural injections, 3 radiofrequency injections, Cortisone injections to the left elbow, left elbow surgery on 10/24/10, physical therapy, and medication. On 2/20/15 noted pain was rated as 7/10. The injured worker had been using Voltaren Gel 1% #1, Orphenadrine/Caffeine, Gabapentin/Pyridoxine, Omeprazole/Flurbiprofen, compounded Flurbiprofen/Cyclobenzaprine/Menthol, Vicosetron (Hydrocodone) since at least 7/2/14. Currently, the injured worker complains of low back pain that radiates to bilateral legs right more than left. Numbness and tingling was noted in the right foot. The treating physician requested authorization for a urine drug screen, Voltaren Gel 1% #1, Orphenadrine/Caffeine 50/10mg #60, Gabapentin/Pyridoxine 250/10mg #60, Omeprazole/Flurbiprofen 10/100mg #60, compounded Flurbiprofen/Cyclobenzaprine/Menthol 20%/10%/4% 180g, Vicosetron (Hydrocodone) 10/300/2mg #4.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Urine Drug Screen: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Screen page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Urine Drug Test.

Decision rationale: According to CA MTUS (2009), a urine drug screen is recommended as an option to assess for the use or the presence of illegal drugs. According to ODG, urine drug testing (UDT) is a recommended tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. In this case, the patient last had a urine drug screen 1/2014. Given the medication usage has remained unchanged and there are no signs that the patient is at high risk for medication abuse, yearly testing is appropriate. Medical necessity for the requested service has been established. The requested service is medically necessary.

Voltaren Gel 1%, qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines, Voltaren Gel 1% (Diclofenac) is indicated for the relief of osteoarthritis in joints that lend themselves to topical treatment, such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. The maximum dose should not exceed 32 g per day. The submitted documentation does not indicate that the injured worker had a diagnosis of osteoarthritis. Additionally, the efficacy of the medication was not submitted for review, nor was it indicated that it helped with any functional deficits that the injured worker had to the knee. In addition, there was no dosage specified for the requested medication. Medical necessity for the requested topical gel has been not established. The requested 1% Voltaren Gel is not medically necessary.

Orphenadrine/Caffeine 50/10mg, qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for Pain).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Orphenadrine.

Decision rationale: According to the ODG, Orphenadrine (Norflex) is a muscle relaxant similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. According to CA MTUS guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory drugs (NSAIDs) alone, and are not recommended for the long-term use of chronic pain. In this case, the patient has been prescribed NSAIDs for breakthrough pain. In addition, there is no guideline support for the use of caffeine in the management of chronic upper extremity and low back pain. Based on the currently available information, the medical necessity for Orphenadrine/Caffeine has not been established. The requested medication is not medically necessary.

Gabapentin/Pyridoxine 250/10mg, qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (Gabapentin). Decision based on Non-MTUS Citation Elbow disorders. In: Hegmann KT, editor(s). Occupational medicine practice guidelines. Evaluation and management of common health problems and functional recovery in workers. 3rd edition, Elk Grove Village (IL): American College of Occupational and Environmental Medicine (ACOEM); 2012. p. 1- 169.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) page(s): 17-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. The records documented that the patient has neuropathic pain related to his chronic pain conditions. In this case, there was no documentation of subjective or objective findings consistent with current neuropathic pain to necessitate use of Neurontin. In addition, there are no guideline recommendations for the use of Pyridoxine for managing elbow complaints. Medical necessity for Neurontin/Pyridoxine has not been established. The requested medication is not medically necessary.

Omeprazole/Flurbiprofen 10/100mg, qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk; NSAIDs. Decision based on Non-MTUS Citation Official Disability Guidelines, Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs, NSAIDs page(s): 67-71.

Decision rationale: Flurbiprofen (Ansaid) is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute low back pain (LBP) and acute exacerbations of chronic pain, and

short-term pain relief in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. According to the California MTUS (2009), Omeprazole (Prilosec), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented GI distress symptoms, or at risk for gastrointestinal events. Flurbiprofen oral will increase the level or effect of omeprazole oral by altering drug metabolism. Medical necessity for Flurb/Omeprazole has not been established. The requested medication is not medically necessary.

Compounded Flurbiprofen/Cyclobenzaprine/Menthol 20%/10%/4%, qty 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Compounded drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. The requested topical analgesic compound for this patient contains: Flurbiprofen 20%, Cyclobenzaprine 10%, and Menthol 4%. MTUS guidelines state that Flurbiprofen, and/or muscle relaxants (Cyclobenzaprine in this case) are not recommended for topical applications. Medical necessity for the requested topical analgesic compounded medication, for muscular pain, has not been established. The requested topical compound is not medically necessary.

Vicosetron (Hydrocodone) 10/300/2mg, qty 40: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the ODG and MTUS guidelines, Vicosetron (Hydrocodone) is a short-acting opioid analgesic. Opioid drugs are available in various dosage forms and strengths. These medications are generally classified according to potency and duration of dosage. The treatment of chronic pain with any opioid analgesic requires review and

documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. In addition, guidelines necessitate documentation that the prescriptions are from a single practitioner and taken as directed. This was not documented in the records. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.