

Case Number:	CM14-0198623		
Date Assigned:	12/08/2014	Date of Injury:	01/14/2003
Decision Date:	02/13/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/25/2014

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 Preventive Medicine 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 79-year-old female with a 1/14/03 date of injury. At the time (9/24/14) of request for authorization for Oxycontin 30mg 1 po q 12 hours #60, Norco 10/325 1 po nte 5/day # 150, Protonix 40mg 1 po qd #30, Ambien CR 6.25mg 1 po qhs #30, Zanaflex 4mg 1-2 po qhs #60, Lidoderm 2 patches #60, Voltaren gel to right S1 joint region, Ativan 1mg 1 po qd to bid prn #45, and TN1 Cream, there is documentation of subjective (chronic low back as well as right hip pain, and neck pain with numbness/tingling over right hand) and objective (tenderness over sacroiliac joint) findings, current diagnoses (lumbosacral radiculitis/neuritis, lumbago, lumbosacral degenerative disc disease, sacroiliitis, and poor sleep), and treatment to date (medications (including ongoing treatment with Oxycontin, Norco, Ambien since at least 1/29/14, Ativan since at least 2012, Zanaflex since at least 1/29/14, Lidoderm patch, TNI cream, and Voltaren gel since at least 2012)). Medical report identifies that baseline urine drug screen was obtained as part of opioid regimen and that the side effects were discussed with the patient; Norco and Oxycontin helps relieve pain; patient has NSAID intolerance; and failure of Gabapentin. Regarding Oxycontin 30mg 1 po q 12 hours #60, there is no documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time; the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing documentation of pain relief, functional status, and appropriate medication use; 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 Oxycontin use to date. Regarding Norco 10/325 1 po nte 5/day # 150, 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 documentation of pain relief, functional status, and

appropriate medication use; 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 Norco use to date. Regarding Protonix 40mg 1 po qd #30, there is no documentation that Protonix is being used as a second-line. Regarding Ambien CR 6.25mg 1 po qhs #30, there is no documentation of short-term (two to six 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 Ambien use to date. Regarding Zanaflex 4mg 1-2 po qhs #60, there is no documentation of acute exacerbations of chronic low back 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 Zanaflex use to date. Regarding Lidoderm 2 patches #60, 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 Lidoderm patch use to date. Regarding Voltaren gel to right S1 joint region, there is no documentation of osteoarthritis pain; short-term use (4-12 weeks); 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 Voltaren gel use to date. Regarding Ativan 1mg 1 po qd to bid prn #45, there is no documentation of the intention for short term use (less than 4 weeks); 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 Ativan use to date. Regarding TN1 Cream, there is no documentation of that trials of anticonvulsants have 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 TNI cream use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 1 PO NTE 5/day # 150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-81.

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 diagnoses of lumbosacral radiculitis/neuritis, lumbago, lumbosacral degenerative disc disease, and sacroiliitis. In addition, there is documentation of ongoing

treatment with Norco. However, despite documentation that baseline urine drug screen was obtained as part of opioid regimen and that the side effects were discussed with the patient, 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 documentation of pain relief, functional status, and appropriate medication use. In addition, despite documentation that Norco helps relieve pain, 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 Norco use to date. Therefore, based on guidelines and a review of the evidence, the request for Norco 10/325 1 po qd # 150 is not medically necessary.

Protonix 40mg 1 PO QD #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Proton Pump Inhibitors (PPIs)

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) 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 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. Official Disability Guidelines identifies documentation of risk for gastrointestinal events, preventing gastric ulcers induced by NSAIDs, and that Protonix is being used as a second-line, as criteria necessary to support the medical necessity of Protonix. Within the medical information available for review, there is documentation of diagnoses of lumbosacral radiculitis/neuritis, lumbago, lumbosacral degenerative disc disease, and sacroiliitis. In addition, there is documentation of ongoing treatment with Protonix. Furthermore, given documentation of ongoing treatment with NSAID, and that patient has NSAID intolerance, there is documentation of risk for gastrointestinal event. However, there is no documentation that Protonix is being used as a second-line. Therefore, based on guidelines and a review of the evidence, the request for Protonix 40mg 1 po qd #30 is not medically necessary.

Ambien CR 6.25mg 1 PO QHS #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, FDA (Ambien)

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

Chapter, Zolpidem and Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS does not address this issue. Official Disability Guidelines identifies Ambien (Zolpidem) as a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. 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 diagnoses of lumbosacral radiculitis/neuritis, lumbago, lumbosacral degenerative disc disease, sacroiliitis, and poor sleep. However, given documentation of ongoing treatment with Ambien since at least 1/29/14, there is no documentation short-term (two to six weeks) treatment. In addition, given documentation of ongoing treatment with Ambien, 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 Ambien use to date. Therefore, based on guidelines and a review of the evidence, the request for Ambien CR 6.25mg 1 po qhs #30 is not medically necessary.

Zanaflex 4mg 1-2 PO QHS #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants; regarding Zanaflex Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs, Tizanidine (Zanaflex) Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain)

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of spasticity, as criteria necessary to support the medical necessity of Zanaflex. 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. Official Disability Guidelines 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 diagnoses of lumbosacral radiculitis/neuritis, lumbago, lumbosacral degenerative disc disease, and sacroiliitis. In addition, there is documentation of Zanaflex used as a second line option. However, there is no documentation of acute muscle spasm, or acute exacerbations of chronic low back pain. In addition, given documentation of ongoing treatment with Zanaflex since at least 1/29/14, there is no (clear) documentation of short-term (less than two weeks) 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 Zanaflex use to date. Therefore, based on guidelines and review of the evidence, the request for Zanaflex 4mg 1-2 po qhs #60 is not medically necessary.

Lidoderm 2 patches #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57. 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 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 diagnoses of lumbosacral radiculitis/neuritis, lumbago, lumbosacral degenerative disc disease, and sacroiliitis. In addition, given documentation of neuropathic pain; and failure of Gabapentin, there is documentation of neuropathic pain after there has been evidence that a trial of first-line therapy (AED (Gabapentin)). However, given documentation of ongoing treatment with Lidoderm patch, 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 Lidoderm patch use to date. Therefore, based on guidelines and a review of the evidence, the request for Lidoderm 2 patches #60 is not medically necessary.

Voltaren gel to right S1 joint region: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel 1% (diclofenac) Page(s): 112.

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 and Other Medical Treatment Guideline for Medical Evidence: Title 8, California Code of Regulations, section 9792.20

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. Official Disability Guidelines 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 diagnoses of lumbosacral radiculitis/neuritis, lumbago, lumbosacral degenerative disc disease, and sacroiliitis. However, despite documentation of pain, there is no (clear) documentation of osteoarthritis pain. In addition, given documentation of ongoing treatment with Voltaren gel since at least 2012, there is no (clear) documentation of short-term use (4-12 weeks). 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 Voltaren gel use to date. Therefore, based on guidelines and a review of the evidence, the request for Voltaren gel to right S1 joint region is not medically necessary.

Ativan 1mg 1 PO QD TO BID PRN #45: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines: regarding Ativan.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. 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 that benzodiazepines are not recommended for long-term and that most guidelines limit use to 4 weeks. Ativan range of action includes anxiolytic, anticonvulsant, and 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. Within the medical information available for review, there is documentation of diagnoses of lumbosacral radiculitis/neuritis, lumbago, lumbosacral degenerative disc disease, and sacroiliitis. However, given documentation of ongoing treatment with Ativan since at least 2012, there is no documentation of the intention for short term use (less than 4 weeks). In addition, 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 Ativan use to date. Therefore, based on guidelines and a review of the evidence, the request for Ativan 1mg 1 po qd to bid prn #45 is not medically necessary.

TN1 Cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. 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 that topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. 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 diagnoses of lumbosacral radiculitis/neuritis, lumbago, lumbosacral degenerative disc disease, and sacroiliitis. However, despite documentation of neuropathic pain; and failure of anticonvulsant (Gabapentin), there is no documentation of that trials of anticonvulsants have failed. In addition, given documentation of ongoing treatment with TNI cream, 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 TNI cream use to date. Therefore, based on guidelines and a review of the evidence, the request for TN1 Cream is not medically necessary.