

Case Number:	CM14-0199208		
Date Assigned:	12/09/2014	Date of Injury:	05/23/1995
Decision Date:	01/22/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/26/2014

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 Occupational 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 52-year-old female with a 5/23/95 date of injury. At the time (10/23/14) of request for authorization for Nine Oxycodone 5mg PRN #60 for lumbar spine, Voltaren gel 1% 2g #3 tubes, Robaxin 500mg #60 for lumbar spine, Lyrica 150mg #30, Senna S tablets 1-2 po-qd, Lidoderm patches #90, Celebrex 200mg #60, and Metamucil powder 661g, there is documentation of subjective (low back pain radiating to bilateral hips) and objective (tenderness over the right lumbar spinous processes, decreased sensation in the right S1 dermatome, and 4/5 muscle strength on right lower extremity) findings, current diagnoses (lumbar/thoracic radiculopathy and back pain), and treatment to date (medications (including ongoing treatment with Oxycodone, Voltaren gel, Robaxin, Lyrica, Senna, Lidoderm patch, Celebrex, and Metamucil powder). Medical report identifies that the patient has constipation. Regarding Nine Oxycodone 5mg PRN #60 for lumbar spine, there is no documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time; 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 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 Oxycodone use to date. Regarding, Voltaren gel 1% 2g #3 tubes there is no 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); 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 Voltaren gel use to date. Regarding Robaxin 500mg #60 for lumbar spine, there is no documentation of 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 Robaxin use to date. Regarding Lyrica 150mg #30, 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 Lyrica use to date. Regarding Lidoderm patches #90, there is no documentation that a trial of first-line therapy (tricyclic 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 specific result of Lidoderm patch use to date. Regarding Celebrex 200mg #60, There is no documentation of high-risk of GI complications with 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 Celebrex use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nine Oxycodone 5mg PRN #60 for lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Oxycodone Page(s): 74-80; 92. 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 moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time, as criteria necessary to support the medical necessity of Oxycontin. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies 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 Oxycontin. 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 lumbar/thoracic radiculopathy and back pain. However, there is no documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. In addition, 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. Furthermore, given documentation of ongoing treatment with Oxycodone, 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 Oxycodone use to date. Therefore, based on guidelines and a review of the evidence, the request for Nine Oxycodone 5mg PRN #60 for lumbar spine is not medically necessary.

Voltaren gel 1% 2g #3 tubes: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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; 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 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. 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 diagnoses of lumbar/thoracic radiculopathy and back pain. However, there is no 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). In addition, there is no documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Furthermore, given documentation of ongoing treatment with Voltaren gel, 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 1% 2g #3 tubes is not medically necessary.

Robaxin 500mg #60 for lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain); 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 Robaxin is recommended for a short course of therapy. 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 diagnoses of lumbar/thoracic radiculopathy and back pain. In addition, given documentation of ongoing treatment with opioid, there is documentation of Robaxin used as a second line agent. However, there is no documentation of acute muscle spasms and acute exacerbation of chronic pain. In addition, given documentation of ongoing treatment with Robaxin, there is no 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 Robaxin use to date. Therefore, based on guidelines and a review of the evidence, the request for Robaxin 500mg #60 for lumbar spine is not medically necessary.

Lyrica 150mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica) Page(s): 19-20. 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, as criteria necessary to support the medical necessity of Lyrica. 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 lumbar/thoracic radiculopathy and back pain. In addition, there is documentation of neuropathic pain. However, given documentation of ongoing treatment with Lyrica, 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 Lyrica use to date. Therefore, based on guidelines and a review of the evidence, the request for Lyrica 150mg #30 is not medically necessary.

Senna S tablets 1-2 po-qd: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids; Initiating therapy Page(s): 77. Decision based on Non-MTUS Citation

Official Disability Guidelines (ODG) Pain, Opioid Induced Constipation; Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: Medical Treatment Guideline identifies documentation of a diagnosis/condition for which DSS is indicated (such as short-term treatment of constipation and/or chronic opioid use), as criteria necessary to support the medical necessity of DSS. MTUS Chronic Pain Medical Treatment Guidelines identifies that when initiating opioid therapy, prophylactic treatment of constipation should be initiated. 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 opioid-induced constipation is a common adverse effect of long-term opioid use. Within the medical information available for review, there is documentation of diagnoses of lumbar/thoracic radiculopathy and back pain. In addition, there is documentation of ongoing treatment with Senna. Furthermore, there is documentation of a diagnosis/condition for which Senna S is indicated (chronic opioid use). Therefore, based on guidelines and a review of the evidence, the request for Senna S tablets 1-2 po-qd is medically necessary.

Lidoderm patches #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 lumbar/thoracic radiculopathy and back pain. In addition there is documentation of neuropathic pain and ongoing treatment with Lidoderm patch. However, given documentation of ongoing treatment with Lyrica, there is no documentation that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica) has failed. In addition, 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 specific result of Lidoderm patch use to date. Therefore, based on guidelines and a review of the evidence, the request for Lidoderm patches #90 is not medically necessary.

Celebrex 200mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22. 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 high-risk of GI complications with NSAIDs, as criteria necessary to support the medical necessity of Celebrex. 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 lumbar/thoracic radiculopathy and back pain. However, there is no documentation of high-risk of GI complications with NSAIDs. In addition, given documentation of ongoing treatment with Celebrex, 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 Celebrex use to date. Therefore, based on guidelines and a review of the evidence, the request for Celebrex 200mg #60 is not medically necessary.

Metamucil powder 661g: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/cdi/metamucil.html> and Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS and ODG do not address this issue. Medical Treatment Guideline identifies documentation of a diagnosis/condition for which Psyllium is indicated (constipation), as criteria necessary to support the medical necessity of Psyllium. 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 lumbar/thoracic radiculopathy and back pain). In addition, there is documentation of a diagnosis/condition for which Metamucil is indicated (constipation). Therefore, based on guidelines and a review of the evidence, the request for Metamucil powder 661g is medically necessary.