

Case Number:	CM14-0205180		
Date Assigned:	12/17/2014	Date of Injury:	05/13/2010
Decision Date:	02/06/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/08/2014

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 Physical Medicine Rehabilitation 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 70-year-old male with a 5/13/10 date of injury. At the time (11/17/14) of request for authorization for Duexis 800-26.6mg #60 with 2 refills, Lidoderm 5% patch #30, and Voltaren 1% gel 4gm #5 with 2 refills, there is documentation of subjective (mild to moderate ongoing right shoulder pain) and objective (tenderness to palpation over the right acromioclavicular joint, biceps groove and glenohumeral joint, decreased right shoulder range of motion, positive impingement tests of the right shoulder, and decreased strength with external rotation) findings, current diagnoses (right shoulder pain), and treatment to date (ongoing therapy with Voltaren gel, Celebrex, Lidoderm patch, and Prilosec since at least 6/9/14). Medical report identifies pain relief and increased activities of daily living with current medication regimen. In addition, medical report identifies a new request for Duexis. Regarding Duexis 800-26.6mg #60 with 2 refills, there is no documentation of rheumatoid arthritis and/or osteoarthritis and Duexis used as second-line therapy following failure of proton pump inhibitors. Regarding Lidoderm 5% patch #30, 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 patch. Regarding Voltaren 1% gel 4gm #5 with 2 refills, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist), 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.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duexis 800-26.6mg #60 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs); NSAIDs, GI Symptoms & Cardiovascular Risk Page(s). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Duexis (Ibuprofen & Famotidine)

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 non-steroidal anti-inflammatory drugs (NSAIDs). In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies that risk for gastrointestinal (GI) 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 (ODG) identifies documentation of rheumatoid arthritis and/or osteoarthritis, and Duexis used as second-line therapy following failure of proton pump inhibitors, as criteria necessary to support the medical necessity of Duexis (ibuprofen & famotidine). Within the medical information available for review, there is documentation of a diagnosis of right shoulder pain. In addition, there is documentation of risk for gastrointestinal event (ongoing therapy with Celebrex). However, despite documentation of right shoulder pain, there is no (clear) documentation of rheumatoid arthritis and/or osteoarthritis. In addition, given documentation of ongoing therapy with Prilosec, there is no documentation of Duexis used as second-line therapy following failure of proton pump inhibitors. Therefore, based on guidelines and a review of the evidence, the request for Duexis 800-26.6mg #60 with 2 refills is not medically necessary.

Lidoderm 5% patch #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57. Decision based on Non-MTUS Citation 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 a diagnosis of right shoulder pain. In addition, there is documentation of ongoing treatment with Lidoderm patch. However, there is no documentation of neuropathic pain. In addition, 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 patch. Therefore, based on guidelines and a review of the evidence, the request for Lidoderm 5% Patch #30 is not medically necessary.

Voltaren 1% gel 4gm #5 with 2 refills: Upheld

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

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 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 (ODG) identifies documentation of failure of an oral non-steroidal anti-inflammatory drugs (NSAIDs) 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 right shoulder pain. In addition, there is documentation of ongoing treatment with Voltaren gel. However, despite documentation of right shoulder pain, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). In addition, given documentation of ongoing treatment with Voltaren gel since at least 6/9/14, there is no documentation of short-term use (4-12 weeks). Furthermore, given documentation of ongoing treatment with oral NSAIDs, 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 1% gel 4gm #5 with 2 refills is not medically necessary.