

<b>Case Number:</b>	CM14-0083712		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	04/30/2008
<b>Decision Date:</b>	01/05/2015	<b>UR Denial Date:</b>	05/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2014

### 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 Family Medicine, and is licensed to practice in North Carolina. 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:

The patient is a 55-year-old with a reported date of injury of 04/30/2008. The patient has the diagnoses of neck sprain/strain, cervical dystonia, degenerative joint disease of the knee and chronic pain syndrome. Per the most recent progress notes provided for review from the primary treating physician dated 04/18/2014, the patient had complaints of constant right knee and shoulder pain. The physical exam noted left knee decreased range of motion with pain, neck with decreased range of motion and pain and spasms in the trapezius. Treatment plan recommendations included trail Botox, bilateral knee braces, left knee Orthovisc Injections and continuation of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zipsor 25mg 1-2 tabs once a day as needed #60:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75-80, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 67.

**Decision rationale:** The California chronic pain medical treatment guidelines section on NSAID therapy states: Recommended at the lowest dose for the shortest period in patients with moderate

to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with Naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Diclofenac Sodium (Voltaren, Voltaren-XR) generic available: (Voltaren, Diclofenac sodium enteric-coated tablet Package Insert), (Voltaren-XR, Diclofenac sodium extended release tablets Package Insert) Diclofenac Potassium (Cataflam, generic available): (Cataflam, Diclofenac potassium immediate-release tablets Package Insert) Different formulations of Diclofenac are not necessarily bioequivalent. Dosing: Cataflam: Osteoarthritis: Adults: 50 mg PO 2--3 times daily. Dosages > 150 mg/day PO are not recommended. Pain: 50mg PO 3 times per day (max dose is 150mg/day). An initial dose of 100 mg PO followed by 50-mg doses may provide better relief. Voltaren: Osteoarthritis: 50 mg PO 2--3 times daily or 75 mg PO twice daily. Dosages > 150 mg/day PO are not recommended. Ankylosing spondylitis: 25 mg PO 4 times a day with an extra 25-mg dose at bedtime if necessary. Voltaren-XR: 100 mg PO once daily for chronic therapy. Voltaren-XR should only be used as chronic maintenance therapy. This medication is recommended for the shortest period of time and at the lowest dose possible. The dosing of this medication is within recommendations per the California MTUS. For these reasons criteria set forth for the use of the medication have been met and therefore the request is medically necessary.

**Tylenol 3 #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief,

side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000)

(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.

(e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control.

(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).

(g) Continuing review of overall situation with regard to nonopioid means of pain control.

(h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse.

When to Continue Opioids

(a) If the patient has returned to work

(b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004)

The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documentation of subjective improvement in pain such as VAS scores. There is also no objective measure of improvement in function. The most recent progress notes actually indicate the patient's pain has gotten worse. For these reasons the criteria set forth above of ongoing and continued use of opioids have not been met. Therefore the request is not medically necessary.