

<b>Case Number:</b>	CM15-0005261		
<b>Date Assigned:</b>	01/16/2015	<b>Date of Injury:</b>	07/12/2013
<b>Decision Date:</b>	03/17/2015	<b>UR Denial Date:</b>	12/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 26 year old male who sustained an industrial related injury on 7/12/13. The injured worker had complaints of low back pain that radiated to the bilateral hips and right lower extremity. Diagnoses included lumbar degenerative disc disease, lumbar radiculopathy, cervical sprain/strain, and sacroillitis. The treating physician requested authorization for Omeprazole 20mg #30, Ultram ER 100mg #30 with 3 refills, and Voltaren gel 1% #1 with 3 refills. On 12/10/14 the requests were non-certified. Regarding Omeprazole the utilization review (UR) physician cited the Medical Treatment Utilization Schedule (MTUS) guidelines and noted there was no evidence that the injured worker is at risk for a gastrointestinal event. Therefore the request was non-certified. Regarding Ultram, the UR physician cited the MTUS guidelines and noted the medical records proved no evidence of an opioid treatment plan with functional goals supporting the use of Ultram. Regarding Voltaren gel, the UR physician cited the MTUS guidelines and noted the injured worker was taking an oral NSAID. There was also no documentation for the use of two formulations of NSAIDS. Therefore the request was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Omeprazole 20mg quantity 30:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 70.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

**Decision rationale:** The patient complains of low back pain that radiates to the bilateral hips and right lower extremity. The current request is for OMEPRAZOLE 20MG #30. The MTUS Guidelines page 68 and 69 states that Omeprazole is recommended with precaution for patients at risk for gastrointestinal events: (1) Age is greater than 65, (2) History of peptic ulcer disease and GI bleeding or perforation, (3) Concurrent use of ASA or corticosteroid and/or anticoagulant, (4) High dose/multiple NSAID. The patient has been taking NSAID on a long term basis and the treating physician continually document GI issues including reflux secondary to medication intake. Given the patient's history of NSAID use and reflux associated with medications, this request IS medically necessary.

**Ultram ER 100mg quantity 30 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Opioids, long term assessment Page(s):.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 88-89,76-78.

**Decision rationale:** The patient complains of low back pain that radiates to the bilateral hips and right lower extremity. The current request is for ULTRAM ER 100MG QUANTITY 30 WITH 3 REFILLS. For chronic opioid use, the MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The patient has been utilizing Ultram since at least 9/25/14. Progress report dated 9/25/14, 10/31/14 and 11/7/14 document current pain level which range from 5/10 to 7/10. There are no further discussions of efficacy of this medication. In this case, recommendation for further use of Ultram cannot be supported as there are no discussions regarding functional improvement, changes in ADL's, or change in work status to document significant functional improvement. There are no before and after pain scales to denote a decrease in pain with using long term opiate. Urine drug screens are not provided and there are no discussions regarding possible aberrant behaviors or adverse side effects with medication. The treating physician has failed to document the minimal requirements of documentation that are outlined in MTUS for continued opiate use. The requested Ultram IS NOT medically necessary and recommendation is for slow weaning per MTUS.

**Voltaren gel 1% quantity 1 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): (s) 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Integrated Treatment/Disability Duration Guidelines, Pain (Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical creams Page(s): 111.

**Decision rationale:** The patient complains of low back pain that radiates to the bilateral hips and right lower extremity. The current request is for VOLTAREN GEL 1% QUANTITY 1 WITH 3 REFILLS. MTUS Guidelines states, "Efficacy and clinical trials for the topical NSAIDs modality has been inconsistent and most studies are small and of short duration. Indications are for osteoarthritis and tendinitis, in particular, that of the knee and elbow and other joints that are amendable to topical treatment, recommended for short-term use for 12 weeks." In this case, the patient does not meet the indication for this medication, as he suffers from chronic back pain. Topical NSAID is recommended for acute and chronic pain conditions, particularly osteoarthritis affecting peripheral joints. The requested Voltaren gel IS NOT medically necessary.