

Case Number:	CM15-0184174		
Date Assigned:	09/24/2015	Date of Injury:	05/08/2008
Decision Date:	11/02/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/18/2015

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: Preventive Medicine, Occupational Medicine

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 65 year old female, who sustained an industrial injury on 05-08-2008. She has reported subsequent low back, left hip and left lower extremity pain and was diagnosed with lumbar radiculopathy, hip pain, sacroiliitis, low back pain and disorder of coccyx. MRI of the lumbar spine on 12-31-2012 showed mild lumbar degenerative changes most pronounced at L4-L5 and L5-S1 and MRI of the left hip dated 08-13-2014 showed minimal to mild arthritis of the left hip with very small degenerative type anterosuperior labral tear. Treatment to date has included oral and topical pain medication, donut pillow and surgery. Medications were noted to enable the injured worker to perform household tasks for a greater duration of time and provided relief of pain. During a 03-27-2015 office visit, the injured worker reported that pain level was increasing and was 10 out of 10 without medication and the physician noted that a sample of Pennsaid solution was provided. During the next office visit dated 04-24-2015, the injured worker's pain level was reported as increased since the last visit but the injured worker reported that Pennsaid helped to reduce pain. In a progress note dated 08-14-2015, the injured worker reported back pain radiating from the low back down the leg hip and hip that was rated as 5 out of 10 with medications and 8 out of 10 without medications. Activity level was noted to remain the same and medications were indicated as working well. Objective examination findings were notable for a slow left sided antalgic gait, restricted range of motion of the lumbar spine and left hip, tenderness, hypertonicity and spasm to palpation of the lumbar paravertebral muscles on both sides, positive left sided straight leg raise test seated at 75 degrees, positive FABER test, tenderness over the coccyx sacroiliac spine, groin and trochanter on the left, motor

testing limited by pain and decreased sensation to light touch over the L5 and S1 dermatomes on the left side. Work status was documented as modified. A request for authorization of Pennsaid 2% pump 20 mg-gram-actuation (2%), Qty 1 with 1 refill, apply 2 pumps 2 times daily to affected area as needed (retrospective DOS 08-14-2015) was submitted. As per the 09-03-2015 utilization review, the request for Pennsaid 2% pump 20 mg-gram-actuation (2%), Qty 1 with 1 refill, apply 2 pumps 2 times daily to affected area as needed (retrospective DOS 08-14-2015) was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pennsaid 2% pump 20 mg/gram/actuation (2%), Qty 1 with 1 refill, apply 2 pumps 2 times daily to affected area as needed, (retrospective DOS 08/14/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter/Pennsaid (Diclofenac Sodium Topical Solution) Section.

Decision rationale: Per the MTUS Guidelines, the use of topical analgesics is recommended as an option for some agents. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Per the ODG, Pennsaid is not recommended as a first-line treatment. Topical diclofenac is recommended for osteoarthritis after failure of an oral NSAID or contraindications to oral NSAIDs, and after considering the increased risk profile with diclofenac, including topical formulations. In studies, Pennsaid was as effective as oral diclofenac, but was much better tolerated. FDA approved Pennsaid Topical Solution in 2009 for the treatment of the signs and symptoms of osteoarthritis of the knee, and the FDA requires a Risk Evaluation and Mitigation Strategy (REMS) from the manufacturer to ensure that the benefits of this drug outweigh its risks. In this case, there is no indication that the injured worker is intolerant to oral NSAIDs. Additionally, she reports that her pain has increased after using the topical Pennsaid, therefore, the request for Pennsaid 2% pump 20 mg/gram/actuation (2%), Qty 1 with 1 refill, apply 2 pumps 2 times daily to affected area as needed, (retrospective DOS 08/14/15) is not medically necessary.