

<b>Case Number:</b>	CM15-0197248		
<b>Date Assigned:</b>	10/12/2015	<b>Date of Injury:</b>	09/27/2010
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2015

### 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: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 63-year-old female, who sustained an industrial injury on September 27, 2010. The initial symptoms reported by the injured worker are unknown. The injured worker was currently diagnosed as having depressive disorder, cervical spine herniated nucleus pulposus, right shoulder rotator cuff tear, bilateral elbow sprain and strain, lateral epicondylitis, bilateral carpal tunnel syndrome, lumbar spine strain and sprain, bilateral knee contusion and bilateral foot strain and sprain. Treatment to date has included medications and diagnostic studies. She noted decreased pain post cortisone injection to the left wrist. On July 16, 2015, the injured worker complained of left wrist pain rated as a 7 on a 1-10 pain scale. Norco was noted to be helpful for the pain, allowing the injured worker to perform activities of daily living. The treatment plan included medications, which were noted to be helpful. On August 26, 2015, the injured worker complained of left wrist pain rated as a 4-5 on a 1-10 pain scale. She also reported lumbar and cervical spine pain. On September 9, 2015, utilization review denied a request for Norco 5-325mg #60, Flurbiprofen cream with one refill, Zantac 150mg #30 with one refill, electric wheelchair and LSO brace. A request for Naproxen 550mg #60 with one refill was authorized.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 5/325mg twice a day quantity 60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, dosing.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** According to the CA MTUS and ODG, Norco 5/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. There is no documentation of significant pain relief or increased function from the opioids used to date. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

**Flurbiprofen cream with one refill: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or anti-depressants. In this case, there is no documentation provided necessitating Flurbiprofen cream. There is no documentation of intolerance to other previous medications. Flurbiprofen, used as a topical NSAID, has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either, not afterward, or with diminishing effect over another two-week period. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). Medical necessity for the requested Flurbiprofen cream has not been established. The requested treatment is not medically necessary.

**Zantac 150mg every day quantity 30 with one refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** Zantac (Ranitidine) is a histamine blocker and antacid used to treat peptic ulcers, gastritis and gastroesophageal reflux (GERD). Zantac works by blocking the effects of histamine on the receptor site known as H2. Proton pump inhibitors (PPI's) are prescribed to both prevent and treat ulcers in the duodenum and the stomach. In most trials, the PPIs have proved to be superior to the H2 blockers. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation of any reported GI complaints. Based on the available information provided for review, the medical necessity for Zantac has not been established. The requested medication is not medically necessary.

**Electric wheelchair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs).

**Decision rationale:** According to the CA MTUS, power mobility devices (PMDs) are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with the manual wheelchair. In this case, the patient can ambulate without assistance and there is no documentation the patient cannot use a manual wheelchair. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

**LSO Brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar Supports.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care.

**Decision rationale:** According to the ACOEM guidelines, lumbar binders, corsets, or support belts are not recommended as treatment for low back pain. The guidelines state that the use of

back-belts as lumbar support should be avoided because they have been shown to have little or no benefit, thereby providing only a false sense of security. In addition, the guidelines do not recommend lumbar braces for treatment of low back pain. In this case, the patient has low back pain however; there is no documentation of instability. Medical necessity for this item has not been established. Therefore, the lumbar brace is not medically necessary.