

<b>Case Number:</b>	CM15-0041026		
<b>Date Assigned:</b>	03/11/2015	<b>Date of Injury:</b>	04/26/2005
<b>Decision Date:</b>	04/23/2015	<b>UR Denial Date:</b>	02/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/04/2015

### 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:

This 49 year old male sustained a work related injury on 04/26/2005. According to a progress report dated 01/12/2015, the injured worker reported back and neck pain. He was not working. He could not function without pain medications. He reported 50 percent reduction in pain and 50 percent functional improvement with activities of daily living with the medications versus not taking them at all. Pain was rated 8 on a scale of 1-10 at, at best a 4 with the medications and 10 without them. The impression was noted as low back with history of lumbar sprain/strain. MRI revealed disc herniation at L5-S1. There was compromise of the bilateral exiting nerve roots with radicular symptoms ongoing. Cervical sprain/strain was noted with severe underlying spondylosis with disc herniation at C5-C6 abutting the spinal cord, similar finding of a lesser degree at C6-C7. There was a history of depression and anxiety disorder with industrial onset. Diabetes and obesity, nonindustrial was also noted. Prescriptions were given for Norco, Voltaren anti-inflammatory gel for myofascial pain, Zanaflex for muscle spasms and Omeprazole for dyspepsia from medications prescribed. Pain level, pain reduction and functional improvement had remained the same since October 2014. According to a previous progress report dated 06/10/2014, the injured worker could not take oral nonsteroidal anti-inflammatory drugs well because they upset his stomach.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 prescription of Norco 10/325mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen; Opioids, criteria for use.

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

**Decision rationale:** This patient has a date of injury of 04/26/14 and presents with neck and back pain, headaches and muscle spasms. The current request is for 1 PRESCRIPTION OF NORCO 10/325MG #120. For chronic opiate use, the MTUS guidelines pages 88 and 89 states, pain should be assessed at each visit and function should be measured at 6-month intervals using a numerical scale or validated instrument. The MTUS page 78 also requires documentation of the 4 A's, which includes analgesia, ADLs, adverse side effects, and aberrant behavior. MTUS also requires 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 Norco since at least 02/04/14. Progress report dated 02/24/14, 10/14/14, 12/11/14 and 02/10/15 all states that pain with medication is 4/10 and without medications pain increases to 10/10. There was a 50% increase in functional improvement with ADL's with medications. Pain contract is on file with the office and UDS have been appropriate. The patient remains off work. In this case, recommendation for further use cannot be supported as the treating physician has not provided any specific functional improvement, changes in ADLs or change in work status to document significant functional improvement with utilizing long term opiate. Furthermore, there are no discussions regarding adverse side effects as required by MTUS for opiate management. The treating physician has failed to provide the minimum requirements as required by MTUS for opiate management. This request IS NOT medically necessary and recommendation is for slow weaning per MTUS.

**1 prescription of Voltaren gel 1% 100g tube: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesic Page(s): 111-113.

**Decision rationale:** This patient has a date of injury of 04/26/14 and presents with neck and back pain, headaches and muscle spasms. The current request is for 1 PRESCRIPTION OF VOLTAREN GEL 1% 100G TUBE. For topical agents, the MTUS Guidelines page 111 states, Topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety. MTUS further states Neuropathic pain: Not recommended as there is no evidence to support. FDA approved agent: Voltaren gel 1% (Diclofenac): Indicated for relief of osteoarthritis pain and joints that lends themselves to topical treatment ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for the treatment of the spine, hip, or shoulder. In this case, the patient presents with neck and low back pain. This patient does not

meet the indication for this medication as he does not present with osteoarthritis and tendinitis. Topical NSAID is recommended for acute and chronic pain conditions, particularly arthritis affecting the peripheral joints. The requested Voltaren gel IS NOT medically necessary.

**1 prescription of Omeprazole 20mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

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

**Decision rationale:** This patient has a date of injury of 04/26/14 and presents with neck and back pain, headaches and muscle spasms. The current request is for 1 PRESCRIPTION OF OMEPRAZOLE 20MG #30. The MTUS Guidelines page 68 and 69 state that omeprazole is recommended with precaution for patients for gastrointestinal events including: ages greater than 65, history of peptic ulcer disease and GI bleeding or perforation, concurrent use of ASA or corticoid and/or anticoagulant, high dose/multiple NSAID. In this case, the patient is not utilizing an oral NSAID to warrant such medication; furthermore, the treating physician has not provided any discussion regarding GI issue such as gastritis, ulcers, or reflux that require the use of this medication. Routine prophylactic use of PPI without documentation of gastric issues is not supported by the guidelines without GI-risk assessment. This request IS NOT medically necessary.