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| <b>Case Number:</b>   | CM15-0054121 |                              |            |
| <b>Date Assigned:</b> | 03/27/2015   | <b>Date of Injury:</b>       | 12/01/2010 |
| <b>Decision Date:</b> | 05/14/2015   | <b>UR Denial Date:</b>       | 02/24/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/23/2015 |

### 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 65-year-old female who reported an injury on 12/01/2010. The mechanism of injury was not provided. The documentation of 01/05/2015 revealed the injured worker had pain in the cervical, thoracic, lumbar, shoulder, bilateral hip, and bilateral knees. The injured worker had tenderness to palpation in the arms over the C5 dermatome, with radiation of pain to the bilateral arms. The injured worker had spasms, tenderness, and guarding of the lumbar spine. The injured worker had a positive Hawkins on the right shoulder. The injured worker had tenderness to palpation over the lateral and medial joint line and patella, and a positive McMurray's. The diagnoses included tendinitis, sprain and strain of lumbar region, cervical and thoracic sprain and strain, and lumbar radiculopathy. The treatment plan included Lidoderm patches 5% quantity #120 with 5 refills, Relafen 750 mg #90 with 5 refills, Ultram ER 100 mg #90 with 5 refills, Prilosec 20 mg #90 with 5 refills, Voltaren gel 60 gm with 5 refills, glucosamine 120 mg with 5 refills, and Flexeril 10 mg #60 with 5 refills. The documentation indicated the injured worker had reached maximum medical improvement.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultram ER 100mg #90 with 5 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 70.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of the above criteria. There was a lack of documentation of exceptional factors. There was a lack of documentation indicating a necessity for 5 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Ultram ER 100 mg #90 with 5 refills is not medically necessary.

**Lidoderm patch 5% #120 with 5 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56, 57.

**Decision rationale:** The California Medical Treatment & Utilization Schedule guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide documentation of a trial and failure of first line therapy. There was a lack of documentation of exceptional factors. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 5 refills without re-evaluation. Given the above, the request for Lidoderm patch 5%, quantity #120 with 5 refills, is not medically necessary.

**Relafen 750mg #90 with 5 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs.

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDs are recommended for short term symptomatic relief of mild to moderate pain. Additionally, the guidelines indicate there should be documentation of objective functional improvement and an objective decrease in pain. There was a lack of documentation of objective functional improvement and an objective decrease in pain. There was a lack of documentation indicate a necessity for 5 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Relafen 750 mg #90 with 5 refills, is not medically necessary.

**Prilosec 20mg #90 with 5 refills:** 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 Page(s): 69.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events. The guidelines additionally indicate that proton pump inhibitors are recommended for injured workers with dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to support the use of NSAIDs. There was a lack of documented efficacy for the requested medication. There was a lack of documentation of a necessity for 5 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Prilosec 20 mg #90 with 5 refills is not medically necessary.

**Voltaren Gel 60gm with 5 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 112.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines indicate that Voltaren Gel 1% (diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). There was a lack of documentation of objective functional benefit that was received previously from the medication. The request as submitted failed to indicate the body part to be treated and the frequency for the requested medication. Additionally, the documentation failed to indicate a necessity for five refills without re-evaluation. Given the above, the request for Voltaren Gel 60 gm with 5 refills is not medically necessary.

**Glucosamine #120 with 5 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine Page(s): 50.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that glucosamine is recommended for injured workers with moderate arthritis pain, especially knee osteoarthritis. The clinical documentation submitted for review failed to provide a rationale for the requested medication. There was a lack of documentation indicating the injured worker had osteoarthritis or that the injured worker had arthritis. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 5 refills without re-evaluation. The efficacy was not provided. Given the above, and the lack of documentation of exceptional factors, the request for Glucosamine #120 with 5 refills is not medically necessary.

**Flexeril 10mg #60 with 5 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review failed to provide a rationale for the requested 5 refills. The injured worker had utilized the medication for an extended duration of time. There was a lack of documentation of objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Flexeril 10 mg #60 with 5 refills is not medically necessary.