

Case Number:	CM15-0082793		
Date Assigned:	05/05/2015	Date of Injury:	04/25/2005
Decision Date:	08/31/2015	UR Denial Date:	04/13/2015
Priority:	Standard	Application Received:	04/30/2015

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: Internal 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 57 year old male who sustained an industrial injury on April 25, 2005. He has reported neck pain and has been diagnosed with chronic pain syndrome, back pain, lumbar with radiculopathy, osteoarthritis shoulders, bilateral severe, neck pain chronic, degenerative disc disease, cervical spine, osteoarthritis, multiple joints, degenerative joint disease, and foot pain, bilateral possibly related to arthritis. Treatment has included medications and physical therapy. Currently the pain was located in the neck, bilateral shoulders, right buttock, left elbow, bilateral knees, bilateral low back, and bilateral ankles and feet. Examination findings showed the injured worker as ambulating with an antalgic gait without use of assistive devices. The treatment request included Voltaren gel, Ambien, oxycodone, OxyContin, imitrex, and Effexor.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% gel (Diclofenac Sodium) #1 with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

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

Decision rationale: According to the California MTUS Guidelines, Voltaren Gel 1% (Diclofenac) is indicated for the relief of osteoarthritis in joints that lend 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. The submitted documentation does indicate that the injured worker had a diagnosis of osteoarthritis. In this case, there is no compelling evidence presented by the treating provider that indicates this injured worker, had any significant improvements from use of this medication, and also review of Medical Records do not indicate that in this injured worker, previous use of this medication has been effective in maintaining any measurable objective evidence of functional improvement. In addition, there was no dosage and frequency specified for the requested medication. Medical necessity for the requested topical gel has been not established. The requested treatment Voltaren 1% gel (Diclofenac Sodium) #1 with 4 refills is not medically necessary.

Ambien 10mg (Zolpidem Tartrate) #30 with 4 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-- Insomnia Treatment.

Decision rationale: Ambien (Zolpidem) is a prescription non-benzodiazepine hypnotic, which is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Ambien can be habit-forming, and may impair function and memory more than opioid analgesics. There is also concern that Ambien may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology, and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, the injured worker has chronic pain, and the submitted documentation does not indicate that Ambien has helped this injured worker. Of note, withdrawal effects can be severe. Abrupt discontinuation should be avoided and tapering is recommended before discontinuation. The requested medication is not medically necessary.

Oxycodone HCL 30mg #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Opioids.

Decision rationale: According to the CA MTUS and the ODG, Oxycodone is a short-acting opioid analgesic indicated for moderate to 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 no documentation of improvement in functional status. 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 treatment with Oxycodone HCL 30mg is not medically necessary.

Oxycontin (Oxycodone HCL) 60mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Opioids.

Decision rationale: According to the CA MTUS and the ODG, Oxycodone is an opioid analgesic indicated for moderate to 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 no documentation of improvement in functional status. 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 treatment with Oxycodone HCL 60mg is not medically necessary.

Imitrex (Sumatriptan Succinate) 50mg #9 with 4 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head Chapter Triptans.

Decision rationale: As per Official Disability Guidelines (ODG) Triptans are recommended for migraine sufferers. At marketed doses, all oral triptans (e.g., sumatriptan, brand name Imitrex) are effective and well tolerated. Differences among them are in general relatively small, but clinically relevant for individual patients. A poor response to one triptan does not predict a poor

response to other agents in that class. In this case, there is no compelling evidence presented by the treating provider that indicates this injured worker, had any significant improvements from use of this medication, and also review of Medical Records do not indicate that in this injured worker, previous use of this medication has been effective in maintaining any measurable objective evidence of functional improvement. The Requested Treatment: Imitrex (Sumatriptan Succinate) 50mg #9 with 4 refills is not medically necessary.

Effexor XR (Venlafaxine HCL) # 30 with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-- Venlafaxine (Effexor®).

Decision rationale: According to the ODG, Venlafaxine (Effexor) is recommended as an option in first-line treatment of neuropathic pain. Venlafaxine is a member of the selective serotonin and norepinephrine reuptake inhibitors (SNRIs) class of antidepressants. It has FDA approval for treatment of depression and anxiety disorders. It is off-label recommended for the treatment of neuropathic pain, diabetic neuropathy, fibromyalgia, and headaches. It may have an advantage over tricyclic antidepressants due to lack of anti-cholinergic side effects. In this case, the patient has symptoms of depression, anxiety, and stress-related medical complaints secondary to an industrial stress injury to the psyche. However, there is no documentation of objective functional benefit with prior medication use. Medical necessity for the requested medication has not been established. Of note, withdrawal effects can be severe. Abrupt discontinuation should be avoided and tapering is recommended before discontinuation. The requested medication is not medically necessary.