

<b>Case Number:</b>	CM14-0127423		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	02/23/1998
<b>Decision Date:</b>	10/27/2014	<b>UR Denial Date:</b>	07/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2014

### 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. The expert reviewer is Board Certified in Pain Medicine and is licensed to practice in Minnesota. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 female who reported an injury on 02/23/1998. The mechanism of injury was not submitted for clinical review. The diagnoses included pain in joint ankle/foot, osteoarthritis, hallux rigidus, acquired deformities, lumbar radiculopathy, and right knee arthritis. Previous treatments included medication. Within the clinical note dated 07/31/2014 it was reported the injured worker complained of left foot pain. She rated her pain 10/10 in severity. Upon the physical examination, the provider noted limited range of motion of the great toe. There was swelling noted in toes 2 through 3. The provider requested Norco, Ambien, Prilosec, Soma, and Biofreeze gel. However, a rationale was not submitted for clinical review. The request for authorization was not submitted for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg one (1) bid #60 x two (2) refills:** 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): 78.

**Decision rationale:** The request for Norco 10/325mg one (1) bid #60 x two (2) refills is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the provider had documented adequate and complete pain assessment within the documentation. There is lack of documentation indicating the medication had been providing objective functional benefit and improvement. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, the request is not medically necessary.

**Ambien 10mg one (1) hs prn #30 x two (2) 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, 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, Zolpidem

**Decision rationale:** The request for Ambien 10mg one (1) hs prn #30 x two (2) refills is not medically necessary. The Official Disability Guidelines note zolpidem is a prescription short acting nonbenzodiazepine hypnotic, which was approved for the short term use, usually 2 to 6 weeks treatment of insomnia. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The clinical documentation submitted failed to indicate the injured worker was treated for or diagnosed with insomnia. Therefore, the request is not medically necessary.

**Prilosec 20mg one (1) qd #30 x two (2) refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines GI symptoms & cardiovascular risk Page(s): 68-69.

**Decision rationale:** The request for Prilosec 20mg one (1) qd #30 x two (2) refills is not medically necessary. The California MTUS Guidelines note proton pump inhibitors such as Prilosec are recommended for injured workers at risk for gastrointestinal events and/or cardiovascular disease. The risk factors for gastrointestinal events include over the age of 65, history of peptic ulcer, gastrointestinal bleeding or perforation, use of corticosteroids and/or anticoagulants. In the absence of risk factors for gastrointestinal bleeding events, proton pump inhibitors are not indicated when taking NSAIDs. The treatment of dyspepsia from NSAID usage includes stopping the NSAID, switching to a different NSAID, or switching to an H2 receptor antagonist or proton pump inhibitor. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Additionally,

there is lack of clinical documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. Therefore, the request is not medically necessary.

**Soma 350mg one (1) qhs #30 x two (2) refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63,64.

**Decision rationale:** The request for Soma 350mg one (1) qhs #30 x two (2) refills with not medically necessary. The California MTUS Guidelines recommend nonsedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The injured worker has been utilizing the medication for an extended period of time (since at least 08/2014) which exceeds the guidelines recommendation of short term use. Therefore, the request is not medically necessary.

**Bio-freeze gel 120 grams x two (2) refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

**Decision rationale:** The request for Bio-freeze gel 120 grams x two (2) refills is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis and tendonitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide a treatment site. Therefore, the request is not medically necessary.