

Case Number:	CM14-0160494		
Date Assigned:	10/06/2014	Date of Injury:	08/29/2013
Decision Date:	10/30/2014	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	09/30/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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:

According to the records made available for review, this is a 42-year-old female with an 8/29/13 date of injury. At the time (9/2/14) of the request for authorization for Naproxen Sodium 550mg QD #30 with 2 refills, Cyclobenzaprine HCL 10mg BID #60, Hydrocodone (Norco 5/325mg) BID #60, and Voltaren gel 1%, there is documentation of subjective (none specified) and objective (paravertebral muscles are tender to palpation, spasms is present, cervical spine and right shoulder range of motion is restricted, impingement sing is positive on the right shoulder, knee effusion noted on the left knee, medial collateral ligament of the left knee and joint lines are tender to palpation bilaterally, anterior talofibular ligaments are tender to palpation bilaterally, lumbar spine range of motion is restricted in flexion) findings, current diagnoses (cervical sprain, shoulder impingement, internal derangement of knee not otherwise specified, sprain of knee, and lumbar sprain/strain), and treatment to date (medication including Naproxen, Cyclobenzaprine, Hydrocodone, and Voltaren gel for at least 5 months). Regarding Naproxen Sodium 550mg QD #30 with 2 refills, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Naproxen use to date. Regarding Cyclobenzaprine HCL 10mg BID #60, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Cyclobenzaprine use to date; acute exacerbation of chronic low back pain; and the intention to treat over a short course (less than two weeks). Regarding Hydrocodone (Norco 5/325mg) BID #60, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a

reduction in the use of medications with Hydrocodone use to date. Regarding Voltaren gel 1%, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and failure of an oral NSAID or contraindications to oral NSAIDs; functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Voltaren gel use to date; and short-term use (4-12 weeks).

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen Sodium 550mg, #30 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical sprain, shoulder impingement, internal derangement of knee not otherwise specified, sprain of knee, and lumbar sprain/strain. In addition, there is documentation of chronic pain. However, given documentation of treatment with Naproxen for at least 5 months, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Naproxen use to date. Therefore, based on guidelines and a review of the evidence, the request for Naproxen Sodium 550mg, #30 with 2 refills is not medically necessary.

Cyclobenzaprine HCL 10mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that Cyclobenzaprine is recommended for a short course of therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are

recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of cervical sprain, shoulder impingement, internal derangement of knee not otherwise specified, sprain of knee, and lumbar sprain/strain. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Cyclobenzaprine use to date. In addition, there is no documentation of acute exacerbation of chronic low back pain. Furthermore, given documentation of treatment with Cyclobenzaprine for at least 5 months, there is no documentation of the intention to treat over a short course (less than two weeks). Therefore, based on guidelines and a review of the evidence, the request for Cyclobenzaprine HCL 10mg, #60 is not medically necessary.

Hydrocodone (Norco 5/325mg), #60: 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): 74-80.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical sprain, shoulder impingement, internal derangement of knee not otherwise specified, sprain of knee, and lumbar sprain/strain. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given documentation of treatment with Hydrocodone for at least 5 months, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Hydrocodone use to date. Therefore, based on guidelines and a review of the evidence, the request for Hydrocodone (Norco 5/325mg), #60 is not medically necessary.

Voltaren gel 1%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Diclofenac sodium

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of Voltaren Gel 1%. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of failure of an oral NSAID or contraindications to oral NSAIDs, as criteria necessary to support the medical necessity of Voltaren Gel. Within the medical information available for review, there is documentation of diagnoses of cervical sprain, shoulder impingement, internal derangement of knee not otherwise specified, sprain of knee, and lumbar sprain/strain. However, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and failure of an oral NSAID or contraindications to oral NSAIDs. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Voltaren gel use to date. Furthermore, given documentation of treatment with Voltaren gel for at least 5 months, there is no documentation of short-term use (4-12 weeks). Therefore, based on guidelines and a review of the evidence, the request for Voltaren gel 1% is not medically necessary.