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| Case Number: | CM14-0213399 | | |
| Date Assigned: | 02/03/2015 | Date of Injury: | 02/01/2007 |
| Decision Date: | 03/06/2015 | UR Denial Date: | 11/19/2014 |
| Priority: | Standard | Application Received: | 12/19/2014 |

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. 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 patient is a 72 year old female with a work injury dated 2/1/07. The diagnoses include carpal tunnel syndrome; cervical spondylosis without myelopathy; pain in the joint-hand; pain in the joint-upper arm. Under consideration are requests for retrospective Odansetron; Lidoderm Patch; Diclofenac Sodium; and Pantoprazole. There is a document dated 10/17/14 that states that the patient returns for follow up of neck and bilateral upper extremity pain. Her pain has increased since her last visits and is a 10/10 today without medications. With medications her pain decreases to 8/10. she notes that her pain causes decreased range of motion in her neck. She complains of numbness and tingling throughout her bilateral upper extremities that affects all digits and radiate to her elbows. She notes that her radicular symptoms wake her up at night. She continues to utilize lidocaine patches and diclofenac cream with benefit of pain relief. She notes that oral medication cause her nausea which she takes Zofran for with benefit. Her review of systems is positive for severe fatigue; dizziness, headaches, neck pain; constipation; heartburn; nausea; numbness; sleep disturbance. Her exam reveals normal upper extremity strength and tone. There are no skin lesions. Her bilateral lower extremity strength is normal. She was given prescriptions for the medications under consideration. The document states that she cannot tolerate oral medications due to nausea and vomiting therefore she will continue Lidoderm and Diclofenac cream and Zofran for nausea. There is a 9/19/14 progress note that the patient has worsening neck and numbness in bilateral forearms and hands bilaterally. She has worsening headaches. She states that her pain begins in the neck and shoots up her head. She states that this causes nausea which induce daily vomiting. She uses Zofran with Relief as well as Lidoderm

patches. Regarding her low back she has trouble with balance and bending. She completed 4/4 massage visits and found they helped reduced her pain. She states that 4 sessions were not enough to make significant progress and she would like more. She does not feel she is able to undergo any surgery. She is not working. On the review of systems she has severe fatigue, dizziness and headaches, numbness, high blood pressure and sleep trouble. On exam she appears in pain and anxious. She has antalgic gait. She has atrophy in the upper extremities with 3/5 bilateral strength in arm abduction, flexion and extension of the forearm and wrist extension bilateral. Her current meds include Protonix, Ketamine cream; Buprenorphine; Odansetron; Colace; Lidoderm patch and blood pressure and cholesterol medications. The treatment includes a prescription for Diclofenac, Protonix, Zofran and Lidoderm patch.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Pantoprazole-protonix (DOS: 9/19/14) Qty: 60.00: 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)- TWC Pain Procedure Summary

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

Decision rationale: Retrospective Pantoprazole-protonix (DOS: 9/19/14) Qty: 60.00 is not medically necessary per the MTUS Guidelines and the ODG. The MTUS guidelines state that the patient is at risk for gastrointestinal events if they meet the following criteria (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The guidelines also state that a proton pump inhibitor can be considered if the patient has NSAID induced dyspepsia. The ODG recommends a trial of Omeprazole or Lansoprazole before Protonix. The documentation does not indicate efficacy of Protonix. The documentation does not indicate that the patient has failed Omeprazole or Lansoprazole therefore the request for Retrospective Pantoprazole-protonix (DOS: 9/19/14) Qty: 60.00 is not medically necessary.

Retrospective Odansetron- Zofran 4mg (DOS: 9/19/14) Qty. 60.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain

Decision rationale: Retrospective Odansetron- Zofran 4mg (DOS: 9/19/14) Qty. 60.00 is not medically necessary per the ODG Guidelines. The MTUS does not specifically address

Odansetron (Zofran). The ODG does not recommend odansetron (Zofran) for nausea/vomiting secondary to chronic opioid use but does recommend for acute use per FDA indications including: to chemotherapy and radiation treatment, postoperative use, or acutely used in for gastroenteritis. There is no documentation that this Odansetron is being used postoperatively, for acute gastroenteritis, or secondary to chemo or radiation treatment therefore this medication is not medically necessary.

Retrospective Lidoderm 5% patch (700mg/patch) (DOS: 9/19/14) Qty:60.00: Upheld

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

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

Decision rationale: Retrospective Lidoderm 5% patch (700mg/patch) (DOS: 9/19/14) Qty:60.00 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines The guidelines state that topical lidocaine 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. The documentation does not indicate failure of first line therapy for peripheral pain. The documentation does not indicate a diagnosis of post herpetic neuralgia. The documentation does not indicate functional improvement on Lidoderm. For these reasons the request for Lidoderm Patch 5% is not medically necessary.

Retrospective Diclofenac Sodium 1.5% 60gm (DOS: 9/19/14) Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC Pain Procedure Summary

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

Decision rationale: Retrospective Diclofenac Sodium 1.5% 60gm (DOS: 9/19/14) Qty: 1.00 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that Diclofenac topical is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (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 perday (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The documentation does not indicate failure of antidepressants and anticonvulsants. The request does

not specify what body part this will be applied on. For these reasons the request for retrospective Diclofenac Sodium 1.5% 60gm (DOS: 9/19/14) Qty: 1.00 is not medically necessary.

Retrospective Pantoprazole- Protonix 20mg (DOS 10/17/14) Qty:60.00: 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)- TWC Pain Procedure Summary

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

Decision rationale: Retrospective Pantoprazole-protonix 20mg (DOS:10/17/14) Qty: 60.00 is not medically necessary per the MTUS Guidelines and the ODG. The MTUS guidelines state that the patient is at risk for gastrointestinal events if they meet the following criteria (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The guidelines also state that a proton pump inhibitor can be considered if the patient has NSAID induced dyspepsia. The ODG recommends a trial of Omeprazole or Lansoprazole before Protonix. The documentation does not indicate that the patient has failed Omeprazole or Lansoprazole therefore the request for Retrospective Pantoprazole-protonix (DOS: 10/17/14) Qty: 60.00 is not medically necessary.

Retrospective Ondansetron- Zofran 4mg (DOS: 10/17/14) Qty: 60.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain

Decision rationale: Retrospective Ondansetron- Zofran 4mg (DOS: 10/17/14) Qty: 60.00 is not medically necessary per the ODG Guidelines. The MTUS does not specifically address Ondansetron (Zofran). The ODG does not recommend ondansetron (Zofran) for nausea/vomiting secondary to chronic opioid use but does recommend for acute use per FDA indications including: to chemotherapy and radiation treatment, postoperative use, or acutely used in for gastroenteritis. There is no documentation that this Ondansetron is being used postoperatively, for acute gastroenteritis, or secondary to chemo or radiation treatment therefore this medication is not medically necessary.

Retrospective Lidoderm 5% Patch (700mg/patch) (DOS: 10/17/14) Qty: 60.00: Upheld

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

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

Decision rationale: Retrospective Lidoderm 5% Patch (700mg/patch) (DOS: 10/17/14) Qty: 60.00 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that topical lidocaine 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. The documentation does not indicate failure of first line therapy for peripheral pain. The documentation does not indicate a diagnosis of post herpetic neuralgia. The documentation does not indicate functional improvement on Lidoderm. For these reasons the request for Lidoderm Patch 5% is not medically necessary.

Retrospective Diclofenac Sodium 1.5% 60gm (DOS: 10/17/14) Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- TWC Pain Procedure Summary

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

Decision rationale: Retrospective Diclofenac Sodium 1.5% 60gm (DOS: 10/17/14) Qty: 1.00 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that Diclofenac topical is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (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). The MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The documentation does not indicate failure of antidepressants and anticonvulsants. The request does not specify what body part this will be applied on. Additionally, there is no evidence of functional improvement on Diclofenac. For these reasons the request for retrospective Diclofenac Sodium 1.5% 60gm (DOS: 9/19/14) Qty: 1.00 is not medically necessary.