

Case Number:	CM15-0013334		
Date Assigned:	01/30/2015	Date of Injury:	05/05/2006
Decision Date:	03/26/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	01/23/2015

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 61 year old female who sustained an industrial injury on 05/05/2006. She complains of low back pain that radiates down to the posterior aspect of both of her lower extremities to her feet. Diagnoses include degenerative disc disease-lumbar, compression fracture-lumbar and bilateral knee pain. Treatment to date has included back brace, knee brace, medications, Transcutaneous Electrical Nerve Stimulation (TENS Unit), interferential stimulator, and knee surgeries. A physician progress note dated 12/12/2014 documents the injured worker has low back pain and bilateral lower extremity pain, and bilateral knee pain. She rates her pain as 9 out of 10. She has low back pain that radiates down to the posterior aspect of both of her lower extremities to her feet. Her pain is throbbing, aching and dull. Her daily activities are limited secondary to pain. The cervical and lumbar range of motion is limited. There is tenderness present over the L2 vertebral body and marked tenderness over the midline of the lower lumbar spine. She has a sensory deficit in the right lower extremity. There is tenderness over the right shoulder and reduced range of motion. Treatment requested is for Norco 10/325mg, #90, Soma 350mg, #90, and Voltaren Gel, #5 with 1 refill. On 01/08/2015 Utilization Review modified the request for Norco 10/325mg, #90, to Norco 10/325mg 45, for weaning purposes, and cited California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines. On 01/08/2015 Utilization Review modified the request for Soma 350mg, #90, to Soma 350mg to 45 for weaning purposes, and cited California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines. On 01/08/2015 Utilization Review non-certified the request Voltaren Gel, #5 with 1 refill, and cited

was California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29.

Decision rationale: This patient presents with low back, bilateral lower extremity and bilateral knee pain. The treater is requesting SOMA 350 MG QUANTITY 90. The RFA was not made available for review. The patient's date of injury is from 05/05/2006 and her current work status was not made available. The MTUS Guidelines page 29 on Carisoprodol -Soma- states that it is not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate -a schedule IV controlled substance. The records show that the patient was prescribed Soma on 08/20/2014. Soma is not recommended for long-term use based on the MTUS guidelines. The request IS NOT medically necessary.

Voltaren Gel, #5 with 1 refill: Upheld

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

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

Decision rationale: This patient presents with low back, bilateral lower extremity and bilateral knee pain. The treater is requesting VOLTAREN GEL QUANTITY 5 WITH ONE REFILL. The RFA was not made available for review. The patient's date of injury is from 05/05/2006 and her current work status was not made available. The MTUS Guidelines page 111 on topical analgesics states that it is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS also states that Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment of osteoarthritis. It is, however, indicated for short term use, between 4-12 weeks. It is indicated for patient with Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. The records show that the patient was prescribed Voltaren gel on 08/20/2014. The MTUS Guidelines page 60 and 61 states that pain assessment and functional changes must also be noted when medications are used for chronic pain. None of the reports note functional improvement while utilizing Voltaren gel. Given the

lack of medication efficacy as it relates to the use of Voltaren gel, the request IS NOT medically necessary.

Norco 10/325mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use of opioids Page(s): 76-78, 88-89, 90.

Decision rationale: This patient presents with low back, bilateral lower extremity and bilateral knee pain. The treater is requesting NORCO 10/325 MG QUANTITY 90. The RFA was not made available for review. The patient's date of injury is from 05/05/2006 and her current work status was not made available. For chronic opiate use, the MTUS guidelines page 88 and 89 on criteria for use of opioids states, "pain should be assessed at each visit, and functioning should be measured at six-month intervals using a numerical scale or validated instrument." MTUS page 78 On-Going Management also require documentation of the 4A's including analgesia, ADLs, adverse side effects, and aberrant drug seeking behavior, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medications to work, and duration of pain relief. The MTUS page 90 notes that a maximum dose for Hydrocodone is 60mg/day. The records show that the patient was prescribed Norco on 08/20/2014. The treater notes medication efficacy stating, "It is somewhat relieved with medications. All of her activities are limited secondary to pain." The patient's current pain level is 9/10. Other than this statement, none of the reports provided show before and after pain scales to show analgesia. There were no specific discussions regarding ADLs. No side effects or aberrant drug seeking behaviors such as urine drug screen or CURES report were provided. Given the lack of sufficient documentation showing medication efficacy for chronic opiate use, the patient should now be slowly weaned as outlined in the MTUS guidelines. The request IS NOT medically necessary.