

<b>Case Number:</b>	CM15-0111274		
<b>Date Assigned:</b>	06/17/2015	<b>Date of Injury:</b>	11/09/2000
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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: Anesthesiology

### 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 70 year old male, who sustained an industrial injury on 11/09/2000. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having pain in the joint of the lower leg, lumbar disc displacement without myelopathy, cervical displacement without myelopathy, and pain in the shoulder joint. Treatment and diagnostic studies to date has included physical therapy, magnetic resonance imaging of the lumbar spine, electromyogram with nerve conduction velocity, magnetic resonance imaging of the brain, magnetic resonance imaging of the left shoulder, and magnetic resonance imaging of the thoracic spine, use of a single point cane, medication regimen, status post left shoulder arthroscopic surgery, status post left total knee replacement, and status post arthroscopic right knee surgery. In a progress note dated 05/13/2015 the treating physician reports complaints of pain to the neck, back, shoulder, upper extremity, and the bilateral knees. The treating physician notes that the injured worker has a lot of pain to the right shoulder with movement. Examination reveals an antalgic gait. The injured worker's current medication regimen includes Docusate Sodium, Orphenadrine-Norflex ER, Fentanyl patch, Fluoxetine-Prozac, Ketamine Cream, Naproxen Sodium, Pantoprazole, and Voltaren Gel. The treating physician requested the medication of a Fentanyl Patch 25mcg/hr with a quantity of 10 with the treating physician noting that the injured worker has 50% relief of pain with this patch along with it assisting with the pain to the back, shoulder and knee allowing him to continue to tolerate his exercises. The treating physician requested Naproxen Sodium 550mg with a quantity 60 for inflammation and pain noting that it assists with improvement in the injured worker's mobility at his joints by decreasing the stiffness. The treating physician requested the medication Pantoprazole (Protonix) 20mg with a quantity 60 to be taken 30

minutes prior to Naproxen to assist with the gastrointestinal upset secondary to the injured worker's medication regimen. The treating physician also requested the medications of Ketamine 5% Cream 60gm with a quantity 1 and Voltaren 1% Gel with a quantity 300 noting current use of these medications, but did not indicate if the injured worker had any functional improvement secondary to use of these medications.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Fentanyl 25mcg/hr patch #10, use one patch, change every 72 hours:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 44.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97.

**Decision rationale:** According to ODG and MTUS, Fentanyl is a long-acting narcotic analgesic used to manage both acute and chronic pain. Fentanyl is an opioid analgesic with a potency of eighty times that of Morphine. Fentanyl transdermal (Duragesic) patches are indicated for the management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. Duragesic patches should only be used in patients who are currently on opioid therapy for which tolerance has developed. Patches are worn for a 72-hour period. In this case, 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. There is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

**Ketamine 5% cream 60gr apply to affected area three times a day, quantity 1:** Upheld

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

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

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical cream contains Ketamine. Ketamine is only recommended for the treatment of neuropathic pain that is refractory to all primary and secondary treatments. There is no documentation of intolerance to other previous oral medications. Medical necessity for the requested topical analgesic

medication has not been established. The requested topical cream is not medically necessary.

**Naproxen Sodium 550mg quantity 60, take one twice daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen Page(s): 66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

**Decision rationale:** Naproxen is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute low back pain (LBP) and acute exacerbations of chronic pain, and short-term pain relief in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, the patient had prior use of NSAIDs without any documentation of significant improvement. There was no documentation of subjective or objective benefit from use of this medication. Medical necessity of the requested medication has not been established. The request for Naproxen is not medically necessary.

**Pantoprazole 20mg quantity 60, take 1 tablet 30 minutes prior to Naproxen twice daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

**Decision rationale:** According to CA MTUS (2009), proton pump inhibitors, such as Pantoprazole (Protonix), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation indicating the patient has any GI symptoms or GI risk factors. In this case, the continued use of NSAID therapy has not been supported as such, there is no need for continuation of a proton pump inhibitor. Based on the available information provided for review, the medical necessity for Pantoprazole has not been established. The requested medication is not medically necessary.

**Voltaren 1% gel quantity 300, apply 2-4gms to affected area three times a day:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 111-112.

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

**Decision rationale:** The California MTUS Guidelines state Voltaren gel 1% (Diclofenac) has an FDA appropriation indicated for the relief of osteoarthritis pain 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 not indicate that the injured worker had a diagnosis of osteoarthritis. Additionally, the efficacy of the medication was not submitted for review, nor was it indicated that it helped with any functional deficits. Medical necessity for the requested topical gel has been not established. The requested 1% Voltaren Gel is not medically necessary.