

<b>Case Number:</b>	CM15-0072877		
<b>Date Assigned:</b>	04/23/2015	<b>Date of Injury:</b>	12/09/2006
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	04/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/16/2015

### 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 49 year old female, who sustained an industrial injury on 12/9/06. She reported back and head injury. The injured worker was diagnosed as having acute and chronic low back pain, lumbalgia, neuralgia, neuritis and radiculitis, rotator cuff syndrome of shoulder, depressive disorder and lumbar intervertebral disc displacement without myelopathy. Treatment to date has included oral medications including narcotics, nerve block, corticosteroid injections and physical therapy. Currently, the injured worker complains of low back, mid back and neck pain with left shoulder pain, headaches and difficulty sleeping. Physical exam noted tenderness to palpation of spine and extremities and decreased range of motion of lumbar spine, cervical spine and left shoulder. The treatment plan included Norco, Soma, Xanax and surgical consultation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #240 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Weaning of Medications Page(s): 94-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** The 50 year old patient complains of pain in right groin, lower back, thoracic spine, cervical spine, and left shoulder along with sleep issues, as per progress report dated 02/07/15. The request is for NORCO 10/325 mg # 240 WITH 3 REFILLS. The RFA for the case is dated 07/24/14, and the patient's date of injury is 12/09/06. Diagnoses, as per progress report dated 02/07/15, included lumbalgia, neuralgia, neuritis/radiculitis and rotator cuff syndrome of the shoulder. Medications included Xanax, Soma and Percocet. The patient is status post SI joint immobilization and status post finger amputation. The patient is temporarily totally disabled and off work, as per the same progress report. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse 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 medication to work and duration of pain relief. In this case, Norco is first mentioned in progress report dated 05/02/14, and the patient has been taking the medication consistently at least since then. The treating physician, however, does not use a validated scale to document reduction in pain and improvement in function. No CURES and UDS reports are available for review. There is no discussion regarding side effects of Norco as well. MTUS guidelines require a clear discussion regarding the 4As, including analgesia, ADLs, adverse side effects, and aberrant behavior, for continued opioid use. Hence, this request IS NOT medically necessary.

**Soma 350mg #60 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Carisoprodol (Soma), Weaning of Medications Page(s): 65.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle  
relaxants Page(s): 63-66.

**Decision rationale:** The 50 year old patient complains of pain in right groin, lower back, thoracic spine, cervical spine, and left shoulder along with sleep issues, as per progress report dated 02/07/15. The request is for SOMA 350 mg # 60 WITH 3 REFILLS. The RFA for the case is dated 07/24/14, and the patient's date of injury is 12/09/06. Diagnoses, as per progress report dated 02/07/15, included lumbalgia, neuralgia, neuritis/radiculitis and rotator cuff syndrome of the shoulder. Medications included Xanax and Percocet. The patient is status post SI joint immobilization and status post finger amputation. The patient is temporarily totally disabled and off work, as per the same progress report. MTUS, Chronic Pain Medication Guidelines, Muscle Relaxants, page 63-66: "Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period." In this case, a prescription for Soma is first noted in progress report dated 07/07/14, and the patient has been taking the medication consistently at least since then. None of the progress reports document its efficacy in terms of reduction in pain and improvement in function. Additionally,

MTUS only supports the use of Soma for a 2 to 3 week period. Hence, the request IS NOT medically necessary.

**Voltaren gel 2mg #60 with 3 refills:** Upheld

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

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

**Decision rationale:** The 50 year old patient complains of pain in right groin, lower back, thoracic spine, cervical spine, and left shoulder along with sleep issues, as per progress report dated 02/07/15. The request is for VOLTAREN GEL 2 mg # 60 WITH 3 REFILLS. The RFA for the case is dated 07/24/14, and the patient's date of injury is 12/09/06. Diagnoses, as per progress report dated 02/07/15, included lumbalgia, neuralgia, neuritis/radiculitis and rotator cuff syndrome of the shoulder. Medications included Xanax and Percocet. The patient is status post SI joint immobilization and status post finger amputation. The patient is temporarily totally disabled and off work, as per the same progress report. The MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Recommended as an option as indicated below. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." Guidelines also do not support the use of topical NSAIDs such as Voltaren for axial, spinal pain, but supports its use for peripheral joint arthritis and tendinitis. In this case, none of the progress reports document the use of Voltaren gel. It is not clear if this is the first prescription or if the patient has used the medication in the past. There is no documentation of efficacy in terms of reduction in pain and improvement in function. Additionally, the patient does not suffer from peripheral joint arthritis or tendinitis for which topical NSAIDs are recommended. Hence, the request IS NOT medically necessary.