

Case Number:	CM13-0033268		
Date Assigned:	12/11/2013	Date of Injury:	08/10/1987
Decision Date:	02/24/2014	UR Denial Date:	09/18/2013
Priority:	Standard	Application Received:	10/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesia, has a subspecialty in Acupuncture and Pain Medicine 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 physician 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:

The patient is a 53 year old male injured worker with date of injury 8/10/87. He has related left knee pain, right knee osteochondritis, and lumbar spine pain. He has been treated with acupuncture, aquatic home therapy, and medications including naproxen 550 mg, Tramadol/APAP 37.5/325 mg and Exoten-C lotion. The injured worker is refractory to cortisone injection to the right knee. An MRI of the right knee was certified in June 2013; the results of which were not available for my review. A urinalysis was performed on 8/16/13, however, the results were not documented. The date of the UR decision was 9/18/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urinalysis (Retrospective): Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 94.

Decision rationale: MTUS CPMTG cites frequent random urine toxicology screens as a step to avoid misuse of opioids, in particular, for those at high risk of abuse. This injured worker is

currently utilizing tramadol in the management of chronic pain. The most recent documentation of urinalysis is dated 2/4/13. This urinalysis yielded inconsistent results in the way of no detection of tramadol when the injured worker was prescribed it. I respectfully disagree with the UR physician, based on this evidence, the request for retrospective urinalysis was medically necessary to detect the potential misuse of opioids.

Tramadol/APAP 37.5/325mg #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78, 93, 113.

Decision rationale: According to MTUS CPMTG p. 93, Tramadol (Ultram) is a synthetic opioid affecting the central nervous system. Tramadol is not classified as a controlled substance by the DEA. Side effects include: Dizziness, nausea, constipation, headache, somnolence, flushing, pruritis, vomiting, insomnia, dry mouth, and diarrhea. Per p. 113, Tramadol is not recommended as a first-line oral analgesic. Per MTUS Chronic Pain Medical Treatment Guidelines p. 78 regarding on-going management of opioids, "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. These domains have been summarized as the '4 A's' (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." Review of the available medical records reveals no documentation to support the medical necessity of Tramadol/APAP, nor any documentation addressing the '4 A's' domains, which is a recommended practice for the on-going management of opioids. Additionally, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Furthermore, efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. Per the 8/16/13 progress report, a urinalysis was performed on this date, however the results remain unavailable for review. As there is no documentation comprehensively addressing this concern, the request is not medically necessary.

Exoten-C lotion 0.002/10/20% #113.4ml: 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 Analgesics Page(s): 105, 111.

Decision rationale: Exoten-C lotion contains methyl salicylate, capsaicin, and menthol. Methyl salicylate may have an indication for chronic pain in this context. Per MTUS p. 105: "Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004)." Capsaicin is recommended as an option in patients who have not responded or are intolerant of other treatments. The CA MTUS, ODG, National Guidelines Clearinghouse, and ACOEM provide no evidence-based recommendations regarding the topical application of menthol. Since menthol is not medically indicated, then the overall product is not indicated per MTUS as outlined below. Note the statement on p. 111: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Though methyl salicylate and capsaicin may be indicated, menthol is not; the preponderance of evidence indicates that overall this medication is not medically necessary. MTUS p.111 states that topical medications are "Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, $\hat{\alpha}$ -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, $\hat{\beta}$ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Regarding the use of multiple medications, MTUS p. 60 states "Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. (Mens, 2005) The recent AHRQ review of comparative effectiveness and safety of analgesics for osteoarthritis concluded that each of the analgesics was associated with a unique set of benefits and risks, and no currently available analgesic was identified as offering a clear overall advantage compared with the others." Therefore, it would be optimal to trial each medication individually. The request is not medically necessary.

Omeprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-steroidal anti-inflammatory agents (NSAIDs).

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

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (1) age over 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). CPMTG guidelines further

specify: "Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.). Patients at intermediate risk for gastrointestinal events and no cardiovascular disease:(1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 Åµg four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)." Because this injured worker is negative for history of peptic ulcer, GI bleeding or perforation, and does not have cardiovascular disease, his risk for gastrointestinal events is low, as such, this request is not medically necessary.