

Case Number:	CM14-0018487		
Date Assigned:	04/18/2014	Date of Injury:	10/21/2010
Decision Date:	09/05/2014	UR Denial Date:	02/06/2014
Priority:	Standard	Application Received:	02/13/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in 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 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/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 injured worker is a 40 year-old male with a date of injury of 10/21/2010. The patient's industrially related diagnoses include unspecific disorders of bursa and tendons of the shoulder region, carpal tunnel syndrome, displacement of lumbar intervertebral disc without myelopathy, lumbago, and other disorders of the shoulder region. The disputed issues are Naproxen 550 mg #30, Omeprazole 20 mg #30, Orphenadrine ER 100 mg #60, Zolpidem 10 mg #30, and Medrox ointment #120 ml. The stated rationale for the denial of Naproxen was that the documentation provided for review does not identify significant functional/vocational benefit with the use of NSAIDs. Therefore ongoing chronic NSAID use was not medically necessary. Omeprazole was not certified because the documentation does not describe current GI symptoms or treatment rendered thus far for GI symptoms such as dietary modification and documentation does not describe risk factors for GI bleed to warrant prophylaxis. The stated reason for non-certification of orphenadrine was that muscle relaxants are supported for only short-term treatment, and given date of injury in 2010, chronic use would not be supported by guidelines. Zolpidem was not certified because the use of Ambien does not appear supported in the current clinical setting. Considering date of injury, use would not fall within the recommended 2-6 week duration of use, and use beyond the 2-6 week period may result in further functional impairment, increased pain levels and levels of depression, which would be counterproductive in the current clinical setting. Lastly, Medrox ointment was not certified because the documentation does not describe well-demarcated neuropathic pain that has failed the gamut of readily available oral agents in the antidepressant, antiepileptic, or nonsteroidal anti-inflammatory class to support the medical necessity of topical agents.

IMR ISSUES, DECISIONS AND RATIONALES

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

NAPROXEN SODIUM 550MG, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 22, 67-68, 73.

Decision rationale: Omeprazole is a PPI. The Chronic Pain Medical Treatment Guidelines referenced above recommend the use of PPIs for patients at intermediate risk for gastrointestinal events and no cardiovascular disease or in patients at high risk of gastrointestinal events with cardiovascular disease. The guidelines list the following to determine if the patient is at risk for gastrointestinal events: (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). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. In the progress notes dated 1/7/2014 and 2/3/2014, there is no documentation that the injured worker reports any GI side effects or that he is at risk for gastrointestinal events for which the Omeprazole is prescribed. According to the above guidelines, PPIs are not recommended for patients with no risk factors and no cardiovascular disease. Therefore Omeprazole is not medically necessary.

OMEPRAZOLE DR 20MG, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPI Page(s): 68-69.

Decision rationale: Omeprazole is a proton pump inhibitor (PPI). The Chronic Pain Medical Treatment Guidelines referenced above recommend the use of PPIs for "patients at intermediate risk for gastrointestinal events and no cardiovascular disease" or in "patients at high risk of gastrointestinal events with cardiovascular disease." The guidelines list the following to "determine if the patient is at risk for gastrointestinal events: (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). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions." In the progress notes dated 1/7/2014 and 2/3/2014, there is no documentation that the injured worker reports any GI side effects or that he is at risk for gastrointestinal events for which the Omeprazole is prescribed. According to the above guidelines, PPIs are not recommended for "patients with no risk factors and no cardiovascular disease." Therefore Omeprazole is not medically necessary.

ORPHENADRINE ER 100MG, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63-66.

Decision rationale: The Chronic Pain Medical Treatment Guidelines on pages 63-64 states the following regarding muscle relaxants, recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008). Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. In addition, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence (Homik, 2004). The injured worker's DOI was 10/21/2010 and he continues to be prescribed Orphenadrine ER 100mg #60 with refills. Based on the guidelines stated above, prolonged use may not only reduce the efficacy of the medication but also cause dependence. Orphenadrine specifically has been reported in case studies to be abused for euphoria and to have mood elevating effects. (Shariatmadari, 1975). Due to the risks associated with prolonged use and the decreased benefit, muscle relaxants are recommended for short-term treatment of acute exacerbations in patients with chronic LBP as stated above. Therefore Orphenadrine is not medically necessary.

ZOLPIDEM TARTRATE 10MG, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG INTEGRATED TREATMENT/DISABILITY DURATION GUIDELINES, STRESS & MENTAL ILLNESS CHAPTER.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Stress & Mental Illness Chapter, Zolpidem.

Decision rationale: The California MTUS and ACOEM do not specifically address zolpidem. Therefore the ODG are utilized which specify the following, Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. It is rarely recommended for long-term use as it can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term (Feinberg, 2008). The injured worker has been prescribed Zolpidem longer than the recommended time for the treatment of insomnia. Due to the risks quoted above, it is recommended to be used for about 2-6 weeks. Furthermore, there is no documentation of good sleep hygiene habits or education which plays a large role in the management of insomnia. Therefore Zolpidem is not medically necessary.

MEDROX OINTMENT 120ML: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CAPSAICIN TOPICAL Page(s): 28-29, 105 AND 113.

Decision rationale: Medrox is a compounded topical medication consisting of methyl salicylate, menthol, and capsaicin 0.0375%. The Chronic Pain Medical Treatment Guidelines on page 111 states any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Thus, each active ingredient should be analyzed in making a determination of medical necessity. The Chronic Pain Medical Treatment Guidelines on page 105 recommend topical salicylate since it is significantly better than placebo in chronic pain. For capsaicin, there are 2 distinct areas of the Chronic Pain Medical Treatment Guidelines where capsaicin is referenced. On pages 28-29 the following statement regarding topical capsaicin is made, Recommended only as an option in patients who have not responded or are intolerant to other treatments. Indications, there are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. The number needed to treat in musculoskeletal conditions was 8.1. The number needed to treat for neuropathic conditions was 5.7 (Robbins, 2000) (Keitel, 2001) (Mason-BMJ, 2004). The results from this RCT support the beneficial effects of 0.025% capsaicin cream as a first-line therapy for OA pain (Altman, 1994). On page 113 of the Chronic Pain Medical Treatment Guidelines, additional commentary on capsaicin includes the following, Capsaicin, Recommended only as an option in patients who have not responded or are intolerant to other treatments. Formulations, Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Indications, There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. The number needed to treat in musculoskeletal conditions was 8.1. The number needed to treat for neuropathic conditions was 5.7. (Robbins, 2000) (Keitel, 2001) (Mason-BMJ, 2004) See also Capsaicin. Given the guidelines, the capsaicin component of Medrox at a 0.0375% concentration is felt to be experimental and not indicated for this injured worker's diagnoses. The Chronic Pain Medical Treatment Guidelines clearly state that there is no evidence to indicate that this increased dosage would provide any further efficacy. Therefore, the request for Medrox is not medically necessary.