MAXIMUS Federal Services

Case Number:	CM14-0125461		
Date Assigned:	08/11/2014	Date of Injury:	07/19/2013
Decision Date:	10/01/2014	UR Denial Date:	08/01/2014
Priority:	Standard	Application Received:	08/07/2014

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 Internal Medicine and is licensed to practice in Virginia and Washington DC. 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:

This is a 58 year old patient who sustained injury on July 19 2013.She developed left shoulder and left arm pain following this. She had issues with left shoulder stiffness and pain which was worsened by lifting, pushing, pulling and reaching and with use of her left arm in an elevated position. She had mid and upper back pain with radiation into her neck. She saw [redacted] who noted fluctuating pain and acupuncture had no benefit. She had been prescribed 10 sessions of acupuncture as well as had ongoing treatment with Tramadol and Naproxen. She saw [redacted] on July 7 2014 who diagnosed her with lateral epicondylitis of the right shoulder and tendinitis of the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550mg (quantity not specified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-70.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen (Naprosyn) Page(s): 66, 72.

Decision rationale: Per MTUS guidelines, Naproxen Naproxen (Naprosyn): delayed release (EC-Naprosyn), as Sodium salt (Anaprox, Anaprox DS, Aleve [otc]) Generic available;

extended-release (Naprelan): 375 mg. Different dose strengths and formulations of the drug are not necessarily bioequivalent. Dosing Information: Osteoarthritis or ankylosing spondylitis: Dividing the daily dose into 3 doses versus 2 doses for immediate-release and delayed-release formulations generally does not affect response. Morning and evening doses do not have to be equal in size. The dose may be increased to 1500 mg/day of Naproxyn for limited periods when a higher level of analgesic/anti-inflammatory activity is required (for up to 6 months). Naprosyn or Naproxyn: 250-500 mg PO twice daily. Anaprox: 275-550 mg PO twice daily. (Total dose may be increased to 1650 mg a day for limited periods). EC-Naprosyn: 375 m g or 500 m g twice daily. The tablet should not be broken, crushed or chewed to maintain integrity of the enteric coating. Naprelan: Two 375 mg tablets (750 mg) PO once daily or two 500 mg tablets (1000 mg) once daily. If required (and a lower dose was tolerated) Naprelan can be increased to 1500 mg once daily for limited periods (when higher analgesia is required). Pain: Naprosyn or Naproxyn: 250-500 mg PO twice daily. The maximum dose on day one should not exceed 1250 m g and 1000 m g on s subsequent days. Anaprox: 275-550 mg PO twice daily. The maximum dose on day one should not exceed 1375 mg and 1100 mg on subsequent days. Extended-release Naprelan: Not recommended due to delay in absorption. (Naprelan Package Insert).The lowest dose for the shortest period for osteoarthritis pain at a maximum of 1100mg per day and this can be continued for six weeks. The patient was prescribed this medication for over this time frame from review of the literature. This would not be clinically indicated.

Tramadol 150mg (quantity not specified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid analgesics and Tramadol Page(s): 82-84, 93-94.

Decision rationale: Per MTUS, Not recommended as a first-line therapy. Opioid analgesics and Tramadol have been suggested as an s econd-line treatment (alone or in combination with first-line drugs). A recent consensus guideline stated that opioids could be considered first-line therapy for the following circumstances: (1) Prompt pain relief while titrating a first-line drug; (2) treatment of episodic exacerbations of severe pain; [&] (3) treatment of neuropathic cancer pain. (Dworkin, 2007) Response of neuropathic pain to drugs may differ according to the etiology of therapeutic pain. There is limited assessment of effectiveness of opioids for neuropathic pain, with short-term studies showing contradictory Results and intermediate studies (8-70 days) demonstrating efficacy. (Eisenberg-Cochrane, 2006) (Eisenberg-JAMA, 2005) The results of short-term trials were mixed with respect to analgesia (less than 24 hours of treatment). Intermediate trials (average treatment duration of 28 days) showed statistical significance for reducing neuropathic pain by 20% to 30% (and 30% may be the threshold for describing a meaningful reduction of pain).Specific Opioids: Tramadol: A recent Cochrane review found that this drug decreased pain intensity, produced symptom relief and improved function for a time period of up to three months but the benefits were small (a 12% decrease in pain intensity from baseline). Adverse events often caused study participants to discontinue this medication, and could limit usefulness. There are no l long-term studies to allow for recommendations for longer than three months. (Cepeda, 2006) Similar findings were found in an evaluation of a formulation

that combines immediate-release vs. extended release Tramadol. Adverse effects included nausea, constipation, dizziness/vertigo and somnolence. (Burch, 2007)Tramadol (Ultram; Ultram ER; generic available in immediate release tablet): Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is not classified as a controlled substance by the DEA. Side Effects: Dizziness, nausea, constipation, headache, somnolence, flushing, pruritus, vomiting, insomnia, dry mouth, and diarrhea. Tramadol may increase the risk of seizure especially in patients taking SSRIs, TCAs and other opioids. Do not prescribe to patients that at risk for suicide or addiction. Warning: Tramadol may produce life-threatening serotonin syndrome, in particular when used concomitantly with SSRIs, SNRIs, TCAs, and MAOIs, and triptans or other drugs that may impair serotonin metabolism. Analgesic dose: Tramadol is indicated for moderate to severe pain. The immediate release formulation is recommended at a dose of 50 to 100mg PO every 4 to 6 hours (not to exceed 400mg/day). This dose is recommended after titrating patients up from 100mg/day, with dosing being increased every 3 days as tolerated. For patients in need of immediate pain relief, which outweighs the risk of non-tolerability the initial starting dose, may be 50mg to 100mg every 4 t o 6 hour s (max 400mg/day). Ultram ER®: Patient currently not on immediate release Tramadol should be started at a dose of 100mg once daily. The dose should be titrated upwards by 100mg increments if needed (Max dose 300mg/day). Patients currently on immediate release Tramdadol, calculate the 24-hour dose of IR and initiate a total daily dose of ER rounded to the next lowest 100mg increment (Max dose 300mg/day). (Product information, Ortho-McNeil 2003) (Lexi-Comp, 2008) The request for Tramadol 150mg is not medically necessary.

10 Acupuncture Sessions, left trapezius and thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines,Chronic Pain Treatment Guidelines NSAIDs,Acupuncture Page(s): 8,264.

Decision rationale: Per MTUS, Acupuncture Medical Treatment Guidelines (a) As used in this section, the following definitions apply: (1) "Acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. (2) "Acupuncture with electrical stimulation" is the use of electrical current (micro-amperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites. (3) "Chronic pain for purposes of acupuncture" means chronic pain as defined in section 9792.20(c). (b) Application (1) These

guidelines apply to acupuncture or acupuncture with electrical stimulation when referenced in the clinical topic medical treatment guidelines in the series of sections commencing with 9792.23.1 et seq., or in the chronic pain medical treatment guidelines contained in section 9792.24.2. (c) Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments.2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(ef). (e) It is beyond the scope of the Acupuncture Medical Treatment Guidelines to state the precautions, limitations, contraindications or adverse events resulting from acupuncture or acupuncture with electrical stimulations. These decisions are left up to the acupuncturist. Most invasive techniques, such as needle acupuncture and injection procedures, have insufficient high quality evidence to support their use. The exception is corticosteroid injection about the tendon sheaths or, possibly, the carpal tunnel in cases resistant to conservative therapy for eight to twelve weeks. For optimal care, a clinician may always try conservative methods before considering an injection. DeQuervain's tendinitis, if not severe, may be treated with a wrist-and-thumb splint and acetaminophen, then NSAIDs, if tolerated, for four weeks before a corticosteroid injection is considered. CTS may be treated for a similar period with a splint and medications before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits). Outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases, though evidence suggests that there is rarely a need for emergent referral. Thus, surgery should usually be delayed until a definitive diagnosis of CTS is made by history, physical examination, and possibly electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis; however, the benefit from these injections is short-lived. Trigger finger, if significantly symptomatic, is probably best treated with a cortisone/anesthetic injection at first encounter, with hand surgery referral if symptoms persist after two injections by the primary care or occupational medicine provider (see Table 11-4). With the clinical documentation provided, there is insufficient evidence to support this medical intervention.