

Case Number:	CM14-0039075		
Date Assigned:	06/27/2014	Date of Injury:	11/20/2009
Decision Date:	12/31/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	04/03/2014

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 Family Medicine and is licensed to practice in Colorado. 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 27 year old female who suffered a work related injury, mechanism unknown, on 11/20/2009. Per the physician notes on 02/10/2014 she had tenderness with palpation at the greater trochanter and range of motion was limited. The right knee was noted to have tenderness to palpation as did the superior pole of the patella, and the inferior medial aspect of the knee over the pes anserine bursa. The impression was right greater trochanteric bursitis due to abnormal gait resulting from right hip pathology, right knee internal derangement, and right pes anserine bursitis. The notes state that the injured worker attended consult for aqua therapy, but has not continued; though aqua therapy in the past helped her muscles relax and alleviated her symptoms significantly. A gym membership was requested so she could do her own aqua therapy. The requested treatments included Ketoprofen, Omeprazole, Orphenadrine, and Norco. The Claims Administrator denied these treatments on 03/12/2014 and the claim was subsequently appealed for Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 75 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti inflammatory drugs) Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines Pain Interventions and Treatments Page(s): 22, 67,70.

Decision rationale: Per the MTUS Guidelines, non-steroidal anti-inflammatory drugs are recommended as second line agents for pain, after trial of Acetaminophen, (particularly for those patients at risk for gastrointestinal events, cardiac events, and renal disease), to be taken at the lowest effective dose for shortest period of time. Non-steroidal anti-inflammatory drugs may be first line for moderate to severe pain, based on available evidence, though studies cannot consistently confirm that non-steroidal anti-inflammatory drugs are superior to Acetaminophen. There is no evidence that any of the non-steroidal anti-inflammatory drugs are effective long term for pain relief or functional improvement. There is no consistent evidence that non-steroidal anti-inflammatory drugs are useful for long term management of neuropathic pain. For the patient of concern, there is no documentation of functional improvement or lasting / objectively rated pain relief from her current regimen which includes Ketoprofen x 6 months or more. Without objective findings of improvement, non-steroidal anti-inflammatory drugs should not be continued long term, given the risk profile. There is also no documentation indicating patient ever tried Acetaminophen prior to non-steroidal anti-inflammatory drugs. The Ketoprofen therefore is not medically indicated.

Omeprazole DR 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS and Gastrointestinal Symptoms Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines Pain Interventions and Treatments Page(s): 68.

Decision rationale: Per the MTUS Guidelines, Prilosec and other Proton Pump Inhibitors can be indicated for use with non-steroidal anti-inflammatory drugs, in those at high risk for gastrointestinal events, or in those on high dose / multiple medications that increase risk of gastrointestinal events. To determine if a patient is at risk for adverse gastrointestinal events, the guidelines establish criteria to consider: (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). For the patient of concern, who is 27 years old, the records do not indicate any diagnosis that would warrant Protonix use. Patient does take non-steroidal anti-inflammatory drug, but the records do not mention gastrointestinal symptoms associated, or a history of gastrointestinal symptoms. The request for Protonix is not medically indicated based on lack of documentation for its need.

Orphenadrine ER 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines Pain Interventions and Treatments Page(s): 63-65.

Decision rationale: Per the Guidelines, muscle relaxers are recommended, as second line therapy for low back pain, primarily acute exacerbations of chronic issue. (Muscle relaxers are prescribed, however, for many musculoskeletal conditions) Some evidence suggests that muscle relaxers may help decrease pain and muscle spasm, and may increase mobility, but those effects are short lived. No benefit has been shown when muscle relaxers are added to non-steroidal anti-inflammatory drugs for pain. Appropriate effects of muscle relaxers diminish over time, and long term use with some can lead to dependence. Therefore, though these medications are commonly prescribed for a variety of conditions, they are not recommended as primary treatment for chronic painful musculoskeletal conditions. Orphenadrine is classified as an anti-spasmodic, and its mechanism of action is unknown, though chemically similar to diphenhydramine. Per the records, the patient of concern has been taking Orphenadrine for at least 3 months. The records indicate that patient reported improved pain with the Orphenadrine as part of her regimen, but there is no documentation of pain ratings or other objective evaluation of pain and /or functional improvement with the muscle relaxer. The guidelines do not support long term use of muscle relaxers given diminishing effects over time, and side effect issues. Per the Guidelines, muscle relaxers are only indicated for short term use. As patient has been using the Orphenadrine much longer than the recommended interval without objective evidence of improvement, the Orphenadrine is not considered medically necessary.

Hydrocodone (Norco) 5/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines Pain Interventions and Treatments Page(s): 79-80, 85, 88-89, and 91.

Decision rationale: The Guidelines establish criteria for use of opioids, including long term use (6 months or more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize the above, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. 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. (Passik, 2000) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to

opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient.3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function.4) Patient has evidence of unacceptable side effects.5) Patient's pain has resolved.6) Patient exhibits "serious non-adherence" Per the Guidelines, Chelminski defines "serious substance misuse" or non-adherence as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005)7) Patient requests discontinuing opioids.8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids Likewise, when making the decision to continue opioids long term, consider the following:Has patient returned to work?Has patient had improved function and decreased pain with the opioids?For the patient of concern, the records do not indicate that any objective, verifiable evaluation of pain and/or functional improvement has been completed despite >6 months of opioid use. The records also do not include any discussion of side effects or any monitoring for aberrant use behavior. Furthermore, the most recent notes available are outdated, at > 6 months in the past. As the records do not include any objective assessment of pain and/or functional improvement, and do not indicate that the "4 A's of Drug Monitoring" have been accomplished, continued opioid therapy with Norco is not medically indicated.