

Case Number:	CM14-0178004		
Date Assigned:	10/31/2014	Date of Injury:	07/21/2008
Decision Date:	01/08/2015	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/27/2014

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 Anesthesia, has a subspecialty in Acupuncture & 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 claimant is a 53-year-old injured worker who sustained an injury associated with industrial exposure to the left upper extremity and left elbow on 07/21/08. The patient slipped and fell on the concrete floor while stepping down, landing to left side and on top of the left upper extremity. The patient felt immediate onset of pain in the entire left upper extremity, from shoulder to arm, elbow and hand. There is also documentation of right knee pain. The patient was diagnosed with cervical discopathy and radiculitis, carpal tunnel syndrome, double crush, cubital tunnel and double crush syndrome, status post right knee arthroscopic surgery with degenerative joint disease with sprain of the anterior cruciate ligament and lateral collateral ligament and status post left knee arthroscopic surgery with degenerative joint disease and tear of the medial meniscus. In regards to imaging, Magnetic resonance imaging (MRI) of the left elbow dated 02/20/12, demonstrated with 1) Joint effusion., 2) 1-centimeter (cm) lesion in the radial head. MRI of the right knee dated 02/20/12 demonstrated with 1) No fractures or dislocations, 2) Joint effusion, 3) Chondromalacia patellae and patellofemoral joint arthropathy, 4) Arthritic changes in the knee-joint as described, 5) Sprain/tear of the anterior cruciate ligament. 6) Sprain of the lateral collateral ligament, 7) Grade 2 signal versus grade 3 tear in the anterior horn of the lateral meniscus, 8) No other meniscal tears visualized. 9) Multilocular cyst in the popliteal fossa, and 10) Cystic changes in the proximal tibia as described. MRI of the left knee dated 02/20/12, demonstrated 1) No fractures or dislocations, 2) Chondromalacia patellae and patellofemoral joint arthropathy, 3) Arthritic changes in the knee-joint, 4) Sprain of the medial collateral ligament, 5) Sprain of the anterior cruciate ligament, 6) Findings were suspicious for a Grade 2 tear of the posterior horn of the medial meniscus, 7) Findings were also suspicious for tears of the anterior and posterior horns of the lateral meniscus. MR arthrography might be considered for further evaluation if clinically desirable and appropriate, 8) Baker's cyst as

described, and 9) Popliteal cyst suspicious for a ganglion cyst as described. X-rays of the cervical spine on 01/24/14, documented disc space height collapse, uncovertebral joint arthrosis and sclerosis at the levels of C5-6 as well as C6-7. According to the Treating Physician's Progress Report and Request for Authorization dated 02/28/14, the patient complained of persistent pain of the neck which radiated to the left upper extremity with numbness and tingling. On examination of the cervical spine, there was tenderness at the cervical paravertebral muscles and upper trapezial muscles with spasm. Axial loading compression test and Spurling's maneuver were positive. There was painful and restricted cervical range of motion. There was dysesthesia at the left C6 and C7 dermatomes. On examination of the left elbow, there was tenderness at the elbow olecranon fossa. Tinel's sign at the elbow was positive. There was pain with terminal flexion. On examination of the knees, there was tenderness at the anterior knee-joint lines. McMurray's sign and patellar compression test were positive. There was pain with terminal flexion. Prior treatments included medications, home exercise program, left arm sling, and injection to the right knee. The patient had been treated with ibuprofen without documented response. The patient had an injection to the right knee on 01/24/14 which helped the symptoms. The patient was status post right knee arthroscopic surgery with degenerative joint disease with sprain of the anterior cruciate ligament and lateral collateral ligament and status post left knee arthroscopic surgery with degenerative joint disease and tear of the medial meniscus. Further treatment plans included consideration of interventional pain management procedures as well as further surgical intervention, including pain management consultation for cervical epidural steroid injection, knee arthroscopic surgery, medications (Anaprox, Prilosec and Zofran and Cidaflex), and follow-up visit for orthopedic evaluation. The patient was advised to work on full duty.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole delayed-release capsules, 20 mg, # 120, provided on September 4, 2012: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms, & Cardiovascular Risk Page(s): 68.

Decision rationale: In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. 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 > 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 g 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 naproxen plus low-dose aspirin plus a PPI.. "As there is no documentation of peptic ulcer, GI bleeding or perforation, or cardiovascular disease in the records available for my review, the injured worker's risk for gastrointestinal events is low, as such, medical necessity cannot be affirmed. On the 2/14 RFA, it is noted that this medication is requested for prophylaxis of naproxen-associated dyspepsia. However, the IW has not been prescribed naproxen, and there was no mention made of any dyspepsia in the most recent note available for review. This is another reason why the request is not medically necessary.

Ondansetron ODT 8 mg, #30 with one refill, provided on September 4, 2012: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Guide

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Antiemetics

Decision rationale: The MTUS is silent on the use of Ondansetron. With regard to antiemetics, the ODG states "Not recommended for nausea and vomiting secondary to chronic opioid use. Recommended for acute use as noted below per FDA-approved indications." Specifically, "Ondansetron (Zofran): This drug is a serotonin 5-HT₃ receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. Acute use is FDA-approved for gastroenteritis." As the injured worker is not postoperative or experiencing nausea and vomiting secondary to chemotherapy and radiation treatment, or gastroenteritis, Ondansetron is not recommended. There was no documentation suggesting the ongoing necessity of the medication or its efficacy. The request is not medically necessary.

Cyclobenzaprine Hydrochloride tablets, 7.5 mg, #120, provided on September 4, 2012: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

Decision rationale: With regard to muscle relaxants, the MTUS CPMTG states: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of

acute exacerbations in patients with chronic LBP. 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." Regarding Cyclobenzaprine: "Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants (e.g. Amitriptyline). Cyclobenzaprine is more effective than placebo in the management of back pain, although the effect is modest and comes at the price of adverse effects." There is no mention of lower back pain nor muscle spasm in the most recent medical record available for my review. As such, the request is not medically necessary.

Medrox pain relief ointment, 120mg with one refill, provided on September 4, 2012: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 60, 105, 111-113.

Decision rationale: Medrox ointment contains Capsaicin, Methyl Salicylate, and Menthol. Per MTUS p 112 "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 injured worker did not have back pain, capsaicin is not indicated. Methyl salicylate may have an indication for chronic pain in this context. Per MTUS p105, "Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain." However, the CA MTUS, ODG, National Guidelines Clearinghouse, and ACOEM provide no evidence-based recommendations regarding the topical application of menthol. It is the opinion of this IMR reviewer that a lack of endorsement, a lack of mention, inherently implies a lack of recommendation, or a status equivalent to "not recommended". Since menthol is not medically indicated, then the overall product is not indicated per MTUS as outlined below. Note the statement on page 111: 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 p60 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. 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.

Cidaflex tablets, #120, provided on September 4, 2012: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine Page(s): 50.

Decision rationale: The MTUS CPMTG states regarding glucosamine "Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis." Per the documentation submitted for review, imaging studies showed knee arthritis. I respectfully disagree with the UR physician's assertion that the injured worker had no arthritis. The request is medically necessary.