MAXIMUS Federal Services

Case Number:	CM15-0100521		
Date Assigned:	06/02/2015	Date of Injury:	09/19/2014
Decision Date:	07/08/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	05/26/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Arizona, Michigan
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 47 year old male with an industrial injury dated 09/19/2014. The mechanism of injury was documented as a fall with injury to left elbow pain and low back pain. Diagnoses included low back pain, left elbow pain and lumbar sprain/ strain. Prior treatment included physical therapy and medications. Co morbid diagnoses included prostate cancer, status post prostatectomy. He presented on 04/15/2015 with complaints of left lateral epicondyle pain and low back pain. There was decreased range of motion of the lumbar spine with tenderness noted on exam. There was also tenderness of the left elbow and left hand. The treatment plan and request included Anaprox 550 mg # 60, Baclofen 2%, Cyclobenzaprine 2%, Flurbiprofen 15%, Lidocaine HCL 6.15%, Hyaluronic acid 0.2% cream; Diclofenac 10%, Flurbiprofen 10%, Gabapentin 10%, Lidocaine HCL 6.15%, Hyaluronic acid 0.2% cream, follow up visit in 4 weeks, pain management consultation for the lumbar spine, Prilosec 20 mg # 60, shockwave therapy times six for the left elbow, quantity: 6 and urinalysis toxicology screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urinalysis toxicology screen: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 222-238, Chronic Pain Treatment Guidelines Drug Testing; Urine testing in ongoing opiate management Page(s): 43 and 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) / Urine Drug testing.

Decision rationale: Per the MTUS, Drug testing is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs before a therapeutic trial of opioids, during ongoing management and to avoid misuse/addiction. Per the ODG, frequency of urine drug testing should be based on documented evidence of risk stratification including use of a testing instrument. A review of the injured workers medical records did not reveal documentation of risk stratification and without this information medical necessity for Urine Drug Test is not established.

Shockwave therapy times six for the left elbow, quantity: 6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33-40.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow (acute and chronic) /Extracorporeal shock wave therapy (ESWT).

Decision rationale: Per MTUS/ ACOEM there is a strong recommendation against using extracorporeal shock wave therapy. Quality studies that are available on extracorporeal shock wave therapy in acute, subacute and chronic lateral epicondylalgia have not shown any benefits. It is moderately costly and has some short-term side effects. Per the ODG, if the decision is made to use this treatment despite the lack of convincing evidence then no more than 3 sessions are recommended over a 3 week period. A review of the injured workers medical records do not reveal anything that would warrant deviating from the guidelines, therefore the request for Extracorporeal Shock Wave Therapy, 6 sessions for left elbow is not medically necessary.

Pain management consultation for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7, Independent Medical Examinations and Consultation, page 127 and 156 and Official Disability Guidelines (ODG) Pain Chapter - Office Visits.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs Page(s): 30-34.

Decision rationale: Per the MTUS, Chronic pain programs are "recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them

at risk of delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria. Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach: (a) the patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis. (c) There is a previous medical history of delayed recovery. (d) The patient is not a candidate where surgery or other treatments would clearly be warranted. (e) Inadequate employer support. (f) Loss of employment for greater than 4 weeks. The most discernable indication of at risk status is lost time from work of 4 to 6 weeks." A review of the injured workers medical records that are available to me did not reveal documentation that the injured worker meets the criteria for a chronic pain program at this time and therefore the request for pain management consultation for the lumbar spine is not medically necessary.

Baclofen 2%, Cyclobenzaprine 2%, Fluriprofen 15%, Lidocaine HCL 6.15%, Hyaluronic acid 0.2%, 150mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 25, 28 and 111-113.

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

Decision rationale: Per the MTUS, topical analgesics are recommended as an option, they are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Muscle relaxants are not supported by the guidelines for topical use. A review of the injured workers medical records that are available to me does not show a trial of recommended first line agents that have failed and therefore based on the guidelines the request for Baclofen 2%, Cyclobenzaprine 2%, Flurbiprofen 15%, Lidocaine HCL 6.15%, Hyaluronic acid 0.2%, 150mg is not medically necessary.

Diclofenac 10%, Fluriprofen 10%, Gabapentin 10%, Lidocaine HCL 6.15%, Hyaluronic acid 0.2% cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 25, 28 and 111-113.

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

Decision rationale: Per the MTUS, topical analgesics are recommended as an option, they are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and

anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. A review of the injured workers medical records that are available to me does not show a trial of recommended first line agents that have failed, the guidelines also do not support the use of Gabapentin as a topical product and therefore the request for Diclofenac 10%, Flurbiprofen 10%, Gabapentin 10%, Lidocaine HCL 6.15%, Hyaluronic acid 0.2% cream is not medically necessary.

Anaprox 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 67 and 68.

Decision rationale: Per the MTUS, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with Naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. A review of the injured workers medical records that are available to me did not reveal documentation of improvement in pain and function with the use of Anaprox and without this information medical necessity for continued use cannot be established.

Prilosec 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68. Decision based on Non-MTUS Citation Food and Drug Administration (Omeprazole).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) / Proton Pump Inhibitors (PPIs).

Decision rationale: Per the MTUS, Clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors according to specific criteria listed in the MTUS and a selection should be made based on these criteria (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). Per the ODG, PPI's are recommended for patients at risk for gastrointestinal events. Prilosec (Omeprazole), Prevacid (Lansoprazole) and Nexium (Esomeprazole Magnesium) are PPIs. Healing doses of PPIs are more effective than all other therapies, although there is an increase in overall adverse

effects compared to placebo. Nexium and Prilosec are very similar molecules. In this RCT Omeprazole provided a statistically significantly greater acid control than Lansoprazole. In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. Studies suggest, however, that nearly half of all PPI prescriptions are used for unapproved indications or no indications at all. Many prescribers believe that this class of drugs is innocuous, but much information is available to demonstrate otherwise. Products in this drug class have demonstrated equivalent clinical efficacy and safety at comparable doses, including Esomeprazole (Nexium), Lansoprazole (Prevacid), Omeprazole (Prilosec), Pantoprazole (Protonix), Dexlansoprazole (Dexilant), and Rabeprazole (Aciphex). (Shi, 2008) A trial of Omeprazole or Lansoprazole had been recommended before prescription Nexium therapy (before it went OTC). The other PPIs, Protonix, Dexilant, and Aciphex, should be second-line. According to the latest AHRQ Comparative Effectiveness Research, all of the commercially available PPIs appeared to be similarly effective. A review of the injured workers medical records did not reveal a past history of gastrointestinal complaints, there was also no current gastrointestinal complaints and no evidence that the injured worker is at increased risk for a gastrointestinal event and therefore the request for Prilosec is not medically necessary.