

Case Number:	CM15-0188214		
Date Assigned:	09/30/2015	Date of Injury:	11/12/2013
Decision Date:	12/02/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/24/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 55-year-old female who sustained an industrial injury on 11-12-2013. Diagnoses have included lumbar sprain or strain, and left lateral epicondylitis. Documented treatment includes rest, ice, "several" steroid injections, physical therapy, a brace, home exercise, and medications including Anaprox, Prilosec, and Neurontin, with an undocumented duration of use prior to the request. On 9-5-2014, the injured worker was reporting low back pain as being "constant and severe" at 9+ out of 10, and the physician noted that she had "decreased range of motion" in the low back, and tenderness at the lateral epicondyle. She also reported "significant difficulty initiating sleep" which was interrupted 2-3 times per night leading to daytime drowsiness. Trial of other medication or treatment is not available in the provided medical records. Retrospective requests for Anaprox #60, Prilosec #30, Neurontin #60 all with dates of service of 9-5-2014; and, 3 treatments of extracorporeal shockwave therapy for the left elbow lateral epicondylitis performed 9-16-2014, 9-30-2014, and 10-14-2014. All were denied on 9-2-2015 deemed medically unnecessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Anaprox DS (Naproxen Sodium) 550mg, #60 with no refill (DOS: 09/05/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk, NSAIDs, hypertension and renal function, NSAIDs, specific drug list & adverse effects, NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: Regarding the request for Naproxen, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Naproxen is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Naproxen is not medically necessary.

Retrospective Prilosec (Omeprazole) 20mg, #30 with no refill (DOS: 09/05/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk, NSAIDs, hypertension and renal function, NSAIDs, specific drug list & adverse effects. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton Pump Inhibitors (PPIs).

Decision rationale: Regarding the request for omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.

Retrospective Neurontin (Gabapentin) 600mg, #60 with no refill (DOS: 09/05/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Regarding request for gabapentin (Neurontin), Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response

is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. Antiepileptic drugs should not be abruptly discontinued but unfortunately there is no provision to modify the current request. As such, the currently requested gabapentin (Neurontin) is not medically necessary.

Retrospective extracorporeal shockwave therapy (ESWT), 3 treatments to the left elbow lateral epicondylitis (DOS: 09/16/2014, 09/30/2014, 10/14/2014): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow - Extracorporeal shockwave therapy (ESWT).

MAXIMUS guideline: Decision based on MTUS Elbow Complaints 2007, Section(s): Lateral Epicondylalgia, Medial Epicondylalgia. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, Extracorporeal shockwave therapy (ESWT).

Decision rationale: Regarding the request for shockwave treatments for the elbow, Occupational Medicine Practice Guidelines state quality studies are available on extracorporeal shockwave therapy in acute, subacute, and chronic lateral epicondylalgia patients and benefits have not been shown. This option is moderately costly, has some short-term side effects, and is not invasive. Thus, there is a recommendation against using extracorporeal shockwave therapy. ODG states extracorporeal shockwave therapy is not recommended. High energy ESWT is not supported, but low energy ESWT may show better outcomes without the need for anesthesia, but is still not recommended. Trials in this area have yielded conflicting results. The value, if any, of ESWT for lateral elbow pain, can presently be neither confirmed nor excluded. After other treatments have failed, some providers believe that shock-wave therapy may help some people with heel pain and tennis elbow. However, recent studies do not always support this, and ESWT cannot be recommended at this time for epicondylitis, although it has very few side effects. As such, the currently requested shockwave treatment for the elbow is not medically necessary.