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| Case Number: | CM15-0195291 | | |
| Date Assigned: | 10/09/2015 | Date of Injury: | 08/21/2014 |
| Decision Date: | 12/16/2015 | UR Denial Date: | 10/05/2015 |
| Priority: | Standard | Application Received: | 10/05/2015 |

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: Emergency 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 65 year old female, who sustained an industrial injury on 8-21-14. The injured worker was diagnosed as having right carpal tunnel syndrome, right ring finger trigger A1 pulley, right elbow internal derangement, left carpal tunnel syndrome and left elbow internal derangement. Medical records (1-13-15 through 4-15-15) indicated bilateral wrist and elbow pain with numbness, tingling and weakness and locking at the right ring finger. The physical exam (1-13-15 through 4-14-15) revealed Finkelstein's, Tinel's and Phalen's test bilaterally, bilateral wrist flexion is 70 degrees and extension is 60 degrees and bilateral elbow flexion is 140 degrees and extension is 0 degrees. As of the PR2 dated 9-15-15, the injured worker reports frequent to constant bilateral wrist and elbow pain with numbness, tingling and weakness. Objective findings include a positive Finkelstein's, Tinel's and Phalen's test bilaterally, bilateral wrist flexion is 70 degrees and extension is 60 degrees and bilateral elbow flexion is 140 degrees and extension is 0 degrees. Current medications include Flexeril (previous prescriptions not documented), Omeprazole, Ibuprofen (previous prescriptions not documented), Relafen (previous prescriptions not documented) and Methoderm gel (previous prescriptions not documented). Treatment to date has included a bilateral hand MRI on 11-8-14 showing osteoarthritis of the 1st CMC joints, bilateral Spica splints, bilateral elbow braces, acupuncture in 6-2015 x 12 sessions and physical therapy for the bilateral elbows, wrists and hands (from at least 5-29-15 through 6-26-15). The treating physician requested Flexeril 10mg #60, Prilosec 20mg #90, Ibuprofen 800mg #60, Relafen 500mg #60, Methoderm gel 240gms and a consultation with a specialist for the bilateral elbows and wrists. The Utilization Review dated

10-5-15, non-certified the request for Prilosec 20mg #90, Ibuprofen 800mg #60, Relafen 500mg #60, Methoderm gel 240gms and a consultation with a specialist for the bilateral elbows and wrists and modified the request for Flexeril 10mg #60 to Flexeril 10mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate documentation of a recent acute exacerbation and poor effectiveness for chronic long-term use, the request is not certified.

Prilosec 20mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The request is for the use of a medication in the class of a proton pump inhibitor. It is indicated for patients with peptic ulcer disease. It can also be used as a preventative measure in patients taking non-steroidal anti-inflammatories for chronic pain. Unfortunately, they do have certain side effects including gastrointestinal disease. The MTUS guidelines states that patients who are classified as intermediate or high risk, should be treated prophylactically. Criteria for risk are as follows: "(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)." Due to the fact the patient was non-certified for an NSAID, there is no need for this medication.

Ibuprofen 800mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

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)/NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The request is for the use of a medication in the NSAID class. The ODG state the following regarding this topic: Specific recommendations: Osteoarthritis (including knee and hip): 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. (Chen, 2008) (Laine, 2008) Back Pain - Acute low back pain & acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting to negative evidence that NSAIDs are more effective than acetaminophen for acute LBP. (van Tulder, 2006) (Hancock, 2007) For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. (Roelofs-Cochrane, 2008) The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. (Hancock, 2007) Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. (Roelofs-Cochrane, 2008) See also Anti-inflammatory medications. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in patients with neuropathic pain. (Namaka, 2004) (Gore, 2006) See NSAIDs, GI symptoms & cardiovascular risk; NSAIDs, hypertension and renal function; & Medications for acute pain (analgesics). Besides the above well-documented side effects of NSAIDs, there are other less well-known effects of NSAIDs, and the use of NSAIDs has been shown to possibly delay and hamper healing in all the soft tissues, including muscles, ligaments, tendons, and cartilage. (Maroon, 2006) The risks of NSAIDs in older patients, which include increased cardiovascular risk and gastrointestinal toxicity, may outweigh the benefits of these medications. (AGS, 2009) As stated above, acetaminophen would be considered first-line

treatment for chronic pain. In this case, the continued use of an NSAID is not supported. This is secondary to inadequate documentation of functional improvement benefit seen. Also, the duration of use places the patient at risk for gastrointestinal and cardiovascular side-effects. In addition, it is known that use of NSAIDs delays the healing of soft tissue including ligaments, tendons, and cartilage. As such, the request is not certified.

Relafen 500mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, specific drug list & adverse effects.

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)/NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The request is for the use of a medication in the NSAID class. The ODG state the following regarding this topic: Specific recommendations: Osteoarthritis (including knee and hip): 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 naproxen being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Back Pain - Acute low back pain & acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting to negative evidence that NSAIDs are more effective than acetaminophen for acute LBP. (van Tulder, 2006) (Hancock, 2007) For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. (Roelofs-Cochrane, 2008) The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. (Hancock, 2007) Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. (Roelofs-

Cochrane, 2008) See also Anti-inflammatory medications. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in patients with neuropathic pain. (Namaka, 2004) (Gore, 2006) See NSAIDs, GI symptoms & cardiovascular risk; NSAIDs, hypertension and renal function; & Medications for acute pain (analgesics). Besides the above well-documented side effects of NSAIDs, there are other less well-known effects of NSAIDs, and the use of NSAIDs has been shown to possibly delay and hamper healing in all the soft tissues, including muscles, ligaments, tendons, and cartilage. (Maroon, 2006) The risks of NSAIDs in older patients, which include increased cardiovascular risk and gastrointestinal toxicity, may outweigh the benefits of these medications. (AGS, 2009) As stated above, acetaminophen would be considered first-line treatment for chronic pain. In this case, the continued use of an NSAID is not supported. This is secondary to inadequate documentation of functional improvement benefit seen. Also, the duration of use places the patient at risk for gastrointestinal and cardiovascular side-effects. In addition, it is known that use of NSAIDs delays the healing of soft tissue including ligaments, tendons, and cartilage. As such, the request is not certified.

Menthoderm gel 240gms: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm049367.htm#MethylSalicylate>

Decision rationale: The request is for the use of a methyl salicylate cream for pain relief. The MTUS and ODG do not address this specific topic. The referenced source states the following: Many athletes use muscle ache creams that contain methyl salicylate. Also known as oil of wintergreen, methyl salicylate is an aspirin-type ingredient of many topical creams that relieves pain. Used correctly, creams containing methyl salicylate can provide temporary relief from minor aches and pains of muscles and joints associated with simple backache, arthritis, strains, bruises and sprains. As with all medications, misuse of these products can cause harm. Segal warns that products with methyl salicylate should not be used for more than seven days and should not be applied to wounds or damaged skin. They should not be used under a tight bandage, and contact with eyes should be avoided. FDA requires the labeling of any drug containing more than 5% methyl salicylate to include warnings that cover such precautions as keeping the product out of children's reach and using the product as directed. As indicated above, the use of this product for muscle aches is indicated for no more than seven days. In this case, further use would not be guideline-supported based on the duration of use. As such, the request is not certified.

Consultation with a specialist, bilateral elbows and wrists: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, page 127.

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)/Office visits.

Decision rationale: The request is for a specialty consultation. The MTUS guidelines are silent regarding this issue. The ODG state the following: Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy. See also Telehealth. In this case, the request is not certified. This is secondary to poor documentation as to the reasoning for the visit and consultation. There is inadequate discussion of the specific issue requiring further evaluation and assessment.