MAXIMUS Federal Services

Case Number:	CM15-0208171		
Date Assigned:	10/27/2015	Date of Injury:	08/19/2013
Decision Date:	12/31/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	10/22/2015

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: Tennessee, Florida, Ohio
Certification(s)/Specialty: Surgery, Surgical Critical Care

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(n) 71 year old female, who sustained an industrial injury on 8-19-13. The injured worker was diagnosed as having bilateral shoulder pain, status post right shoulder surgery and left ankle contusion. Subjective findings (3-31-15, 4-28-15) indicated pain in the bilateral shoulders and left ankle. The injured worker rated her left shoulder pain 7-9 out of 10 without medications and 5-6 out of 10 with medications, right shoulder pain 4 out of 10 without medications and 2 out of 10 with medications and left ankle pain 0-5 out of 10 with medications and 2-6 out of 10 without medications. Objective findings (3-31-15, 4-28-15) revealed painful range of motion in the bilateral shoulders and tenderness to palpation of the anterior left ankle and bilateral acromioclavicular joints. Treatment to date has included physical therapy, acupuncture, Cyclobenzaprine (since at least 3-31-15), Omeprazole and Anaprox. The Utilization Review dated 9-24-15, non-certified the request for Flurbiprofen 10%, Gabapentin 6%, Baclofen 2%, Lidocaine 4%, Cyclobenzaprine 2%, Microderm base cream, DOS: 05/06/15, Diclofenac 100mg DOS 4-28-15, Prilosec 20mg #60 DOS 4-28-15, Cyclobenzaprine 7.5mg #60 DOS 4-28-15, a hot-cold unit DOS 4-28-15 and a UA toxicology DOS 4-28-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 10%, Gabapentin 6%, Baclofen 2%, Lidocaine 4%, Cyclobenzaprine 2%, Microderm base cream, DOS: 05/06/15: Upheld

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

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. Per the California MTUS Chronic Pain guidelines, topical analgesics are not recommended as an option for chronic pain control and are largely experimental in use with few randomized control trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended as a whole. The requested cream is a combination of multiple medications. Compounded medications are not FDA approved or recommended by ODG guidelines due to concerns of purity and efficacy. Hence, the request for this compounded medication is not appropriate or indicated by MTUS and ODG guidelines. Therefore, based on the submitted medical documentation, the request for Flurbiprofen 10%, Gabapentin 6%, Baclofen 2%, Lidocaine 4%, Cyclobenzaprine 2%, Microderm base cream is not medically necessary.

Diclofenac sodium 100mg, DOS: 04/28/15: Upheld

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

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of treatment of this medication for this patient. The California MTUS guidelines address the topic of NSAID prescriptions by stating, "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." The MTUS guidelines do not recommend routine use of NSAIDS due to the potential for adverse side effects (GI bleeding, ulcers, renal failure, etc). The medical records do not support that the patient has a contraindication to other non-opioid analgesics. Therefore, medical necessity for XX prescription has not been established.

Prilosec/Omeprazole 20mg #60, DOS: 04/28/15: 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: There is not sufficient clinical information provided to justify the medical necessity of the requested prescription for this patient. The clinical records submitted do not support the fact that this patient has refractory GERD resistant to H2 blocker therapy or an active h. pylori infection. The California MTUS guidelines address the topic of proton pump prescription. In accordance with California MTUS guidelines, PPI's (Proton Pump Inhibitors) can be utilized if the patient is concomitantly on NSAIDS and if the patient has gastrointestinal risk factors. This patient is not on NSAIDS. Additionally, per the Federal Drug Administration's (FDA) prescribing guidelines for PPI use, chronic use of a proton pump inhibitor is not recommended due to the risk of developing atrophic gastritis. Short-term GERD symptoms may be controlled effectively with an H2 blocker unless a specific indication for a proton pump inhibitor exists. This patient's medical records do not support that he has GERD. Furthermore, the patient has no documentation of why chronic PPI therapy is necessary. The patient is not documented to be refractory to H2 blocker therapy and they have no records that indicate an active h. pylori infection. Therefore, based on the submitted medical documentation, the request for Prilosec prescription is not medically necessary.

Cyclobenzaprine 7.5mg take 1-2 tablet #60, DOS: 04/28/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. In accordance with the California MTUS guidelines, Cyclobenzaprine is a muscle relaxant and muscle relaxants are not recommended for the treatment of chronic pain. From the MTUS guidelines: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic back pain." Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. This patient has been diagnosed with chronic back pain of the cervical and upper spine. Per MTUS, the use of a muscle relaxant is not indicated. Therefore, based on the submitted medical documentation, the request for Cyclobenzaprine is not-medically necessary.

Hot/Cold unit, DOS: 04/28/15: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, and Ankle and Foot Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, continuous-flow cryotherapy.

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The MTUS Chronic Pain Guidelines do not address the topic of shockwave therapy. ACOEM Guidelines state, "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neuro-stimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely." The Official Disability Guidelines note that hot cold therapy is not recommended for patients whose pain has remained despite standard treatment. Within the provided documentation, the requesting physician did not include an adequate and complete assessment of the patient's current objective functional condition in order to demonstrate functional deficits needing to be addressed with the treatments. Therefore, based on the submitted medical documentation, the request for hot/cold therapy is not medically necessary.

UA toxicology - unknown panel, DOS: 04/28/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Urine Drug Testing (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a urine drug screen for this patient. The clinical records submitted do not support the fact that this patient has been documented to have a positive drug screen for illicit or non-prescribed substances. The MTUS guidelines recommend frequent and random urine drug screens where aberrant behavior is suspected. This patient has not been documented to have suspicion of aberrant behavior. His pain is documented as well controlled and past drug screens are consistent with currently prescribed medications. Therefore, based on the submitted medical documentation, the request for drug screening is not-medically necessary.