

Case Number:	CM15-0028159		
Date Assigned:	02/20/2015	Date of Injury:	03/21/2011
Decision Date:	04/10/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/13/2015

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 62-year-old female, who sustained an industrial injury on March 21, 2011. The injured worker had reported a left mid-back and left elbow injury related to a fall. The diagnoses have included sprain of the shoulder and sprain of the wrist. Treatment to date has included pain medication and physical therapy. Current physical therapy documentation dated July 18, 2014 notes that the injured worker complained of shoulder and arm pain. Active range of motion was within normal limits. The injured worker reported unspecified pain with each visit. No physical examination was noted. On January 28, 2015 Utilization Review non-certified a request for a retrospective trigger point injection with Dexmetha 1mg on 01/07/2015, Omeprazole 20 mg #30, Orphenadrine 100 mg #60, Nabumetone 750 mg #20 and Tramadol/APAP 37.5/325 mg #30. The MTUS, ACOEM Guidelines and the Official Disability Guidelines, were cited. On February 13, 2015, the injured worker submitted an application for IMR for review of a retrospective trigger point injection with Dexmetha 1mg on 01/07/2015, Omeprazole 20 mg #30, Orphenadrine 100 mg #60, Nabumetone 750 mg #20 and Tramadol/APAP 37.5/325 mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trigger point injection with dexmetha 1mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

Decision rationale: Per the MTUS, Trigger point injections are recommended only for myofascial pain syndrome. TPIs with a local anesthetic may be recommended for the treatment of myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) No more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief with reduced medication use is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) TPIs with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended; Unfortunately a review of the medical records that are available to me do not meet the above referenced criteria, therefore the request for Trigger point injection with dexmethal 1mg is not medically necessary.

Omeprazole 20mg # thirty (30): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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.

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. (Donnellan, 2010) In this RCT, omeprazole provided a statistically significantly greater acid control than lansoprazole. (Miner, 2010) 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. (AHRQ, 2011). A review of the injured workers medical records that are available to me do not show that the injured worker has any gastrointestinal risk factors and therefore the request for Omeprazole 20mg # thirty (30) is not medically necessary.

Orphenadrine 100mg # sixty (60): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physician Desk Reference (PDR)Orphenadrine.

Decision rationale: The MTUS, ACOEM and ODG did not address the use of orphenadrine in the injured worker, therefore other guidelines were consulted. In the PDR, orphenadrine is described as a centrally acting muscular analgesic and is used as an adjunct to rest, physical therapy and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions. However a review of the injured workers medical records do not show a failed trial of other first line recommended treatments and therefore the request for orphenadrine is not medically necessary.

Nabumetone 750mg # twenty (20): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

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 provide adequate subjective and objective documentation of the injured workers pain and without this information medical necessity cannot be established.

Tramadol/APAP 37.5/325 # thirty (30): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96 (78).

Decision rationale: Per the MTUS, Opioids should be continued if the patient has returned to work or has improved functioning and pain. Ongoing management should follow the 4 A's of analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Long-term users of opioids should be regularly reassessed. In the injured workers medical records that are available to me, there was no documentation of improved functioning and pain per the MTUS criteria for on-going management, therefore the request for Tramadol/APAP 37.5/325 # thirty (30) is not medically necessary.