MAXIMUS Federal Services

Case Number:	CM15-0033091		
Date Assigned:	02/26/2015	Date of Injury:	08/28/2014
Decision Date:	04/15/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/23/2015

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 25-year-old male with an industrial injury on 08/28/2014. He states he was unloading a truck and felt a sharp pain in his low back. Progress note dated 11/14/2014 states he is having right lumbar radiculopathy with tingling and pain radiating down the right leg as well as low back pain and spasm. Physical exam showed tenderness to the right lumbar area. Straight leg raising was positive on the right at 45 degrees. Prior treatment included physical therapy and medications. MRI dated 09/12/2014, demonstrated at lumbar 4-5 dis desiccation with a broad-based disc bulge measuring 3 mm and demonstrating an annular tear. Diagnoses: Right lumbar 4-5 disc protrusion with annular tear; Right lumbar 4-5 radiculopathy. On 01/30/2015 utilization review issued the following decisions: The request for physical therapy to lumbar spine times 12 were non-certified. MTUS was cited. The request for Hydrocodone 10/325 mg # 60 was modified to Hydrocodone 10/325 mg # 30. MTUS was cited. The retrospective request for Naproxen Sodium 550 mg # 90 was non-certified. MTUS was cited. The retrospective request for Pantoprazole 20 mg # 90 was non-certified. MTUS was cited. The request for retrospective Cyclobenzaprine 7.5 mg # 90 was non-certified. MTUS was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: Per the MTUS, physical therapy is recommended following specific guidelines, allowing for fading of treatment frequency from up to three visits per week to one or less, plus active self directed home physical medicine. For myalgia and myositis unspecified, the guidelines recommend 9-10 visits over 8 weeks. Neuralgia, neuritis and radiculitis unspecified 8-10 visits over 4 weeks. It would appear that the request for Physical therapy 12 visits to the lumbar spine exceeds the guideline recommendations of up to 10 visits and is not medically necessary.

Hydrocodone 10/325mg #60: Overturned

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 (78,95).

Decision rationale: Per the MTUS, opioids should be continued if the patient has returned to work or has improved functioning and pain. On going management should follow the 4 'A's of analgesia, activities of daily living, adverse side effects, and abberrant drug taking behaviors. Long-term users of opioids should be regularly reassessed. Also, patients who receive opioid therapy may sometimes develop unexpected changes in their response to opioids, which includes development of abnormal pain, change in pain pattern, persistence of pain at higher levels than expected. when this happens opioids can actually increase rather than decrease sensitivity to noxious stimuli. it is important to note that a decrease in opioid efficacy should not always be treated by increasing the dose or adding other opioids, but may actually require weaning. In the injured workers medical records that are available to me, there is adequate documentation to support the criteria for ongoing management of opioids and the injured worker appears to be having a satisfactory response to opioids therefore the request for Hydrocodone 10/325mg #60 is medically necessary.

Retro: Naproxen Sodium 550mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's 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 reveal subjective and objective documentation of the injured workers pain and the use of an NSAID would be appropriate in the injured worker, therefore the request for Naproxen sodium 550mg #90 is medically necessary.

Retro: Pantoprazole 20mg #90: Overturned

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 (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. (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 reveal documentation of a history of gastrointestinal upset with NSAID's that is relieved with the use of PPI's, specifically the three times a day dosing was described as most effective. Therefore based on the injured workers clinical presentation and the guidelines the request for pantoprazole 20mg #90 is medically necessary.

Retro: Cyclobenzaprine 7.5mg #90: 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 Cyclobenzaprine (Flexeril) Page(s): 41-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PaIn (Chronic).Cyclobenzaprine (Flexeril).

Decision rationale: Regarding the request for cyclobenzaprine, the MTUS recommends a short course of this medication as an option in the management of chronic pain. The effect of cyclobenzaprine is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Per the ODG, this medication is not recommended to be used for longer than 2-3 weeks. The injured worker does not appear to be a candidate for continued use of cyclobenzaprine. Records reflect the injured worker has been prescribed cyclobenzaprine on a long-term basis, and guidelines do not recommend use for over 2-3 weeks. Continued use of cyclobenzaprine would not fall within guideline recommendations and would put the injured worker at increased risk for adverse effects. Therefore, the request for Cyclobenzaprine 7.5mg #90 is not medically necessary.