

Case Number:	CM15-0111807		
Date Assigned:	06/18/2015	Date of Injury:	10/01/2011
Decision Date:	07/21/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	06/09/2015

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: Internal 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:

This 50 year old female sustained an industrial injury to the left upper extremity on 10/1/11. Recent treatment included medication management. In a progress note dated 4/22/15, the injured worker rated her pain 4/10 on the visual analog scale with medications and 7/10 without medications. The injured worker had been taking Tylenol with codeine and Neurontin. The injured worker complained of a one week history of gastrointestinal irritation with medications. The injured worker stopped taking the medications and had a subsequent flare up of pain. Physical exam was remarkable for decreased left grip strength, intact gross sensation with decreased left wrist passive range of motion. The injured worker was working modified duty. Current diagnoses included left wrist sprain/strain. The treatment plan included holding Tylenol with codeine for one week, continuing Neurontin, dispensing Tylenol with codeine to be used after one week, dispensing Prilosec to help with gastrointestinal upset and dispensing Terocin patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Omeprazole 20mg #60 DOS: 4/22/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & Cardiovascular risk Page(s): 68-69.

Decision rationale: Based on MTUS guidelines, clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulation; or (4) high dose/multiple NSAID (e.g., NSAID + low dose ASA). The recommendations are as follow. Patients with no risk factors and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.). Patients at intermediate risk for gastrointestinal events with no cardiovascular disease: (1) A non-selective NSAID with either a PPI (proton pump inhibitor, for example, 20 mg of omeprazole daily) or misoprostol (200 mcg four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (>1 year) has been shown to increase the risk of hip fracture. Patients at high risk for gastrointestinal events and no cardiovascular disease: A Cox-2 selective agent plus a PPI is absolutely necessary. In this case, the patient appears to be at low risk for gastrointestinal events as she is less than 65 years old, does not have a history of peptic ulcer disease, or GI bleeding and is not on high dose or combination NSAID therapy. Even though she did experience some gastrointestinal side effects from Tylenol 30/300, this does not indicate use a proton pump inhibitor such as Omeprazole. Therefore, based on the information in this case and review of the MTUS guidelines, the request for Omeprazole 20 mg #60 is not medically necessary.

Retro Tylenol 30/300mg #30 DOS: 4/22/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain Page(s): 80-81.

Decision rationale: Based on MTUS guidelines, opioids (such as Tylenol 30/300) have been suggested for neuropathic pain that has not responded to first-line recommendations (anti-depressants, anticonvulsants). There are no trials for long-term use. There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant neuropathy. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (<= 70 days). This lead to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and /or opioid abuse, and the influence of placebo as a variable for treatment. Long-term, observational studies have found that treatment with opioids tends to provide improvement in function and minimal

risk of addiction, but many of these studies include a high dropout rate. There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain. Current studies suggest that the "upper limit of normal" for opioids prior to evaluation with a pain specialist for the need for possible continuation of treatment, escalation of dose, or possible weaning, is in the range from 120-180 mg morphine equivalents a day. In this case, there is no documentation that this patient has failed first line treatment with antidepressants/anticonvulsants, Tylenol, aspirin or NSAIDs. Therefore based on MTUS guidelines, the request for Tylenol 30/300 mg #30 is not medically necessary.

Retro Lidocaine patch DOS: 4/22/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Patch Topical Analgesics Page(s): 56-57; 111-113.

Decision rationale: Based on MTUS guidelines, topical analgesics are recommended as an option and are largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI antidepressants or an anti-epileptic drug such as gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. It is not recommended for non-neuropathic pain. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. In this case, there is no documentation that this patient has tried and failed first line treatments such as tricyclic antidepressants or antiepileptic drugs. Also, there is no indication that this patient has either neuropathic pain or post-herpetic neuralgia. Therefore, based on the MTUS guidelines and the evidence in this case, the request for Lidocaine patch is not medically necessary.