

Case Number:	CM15-0136393		
Date Assigned:	07/24/2015	Date of Injury:	07/01/2009
Decision Date:	11/16/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	07/14/2015

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:

This is a 49-year-old female worker who was injured on 7-1-2009. The medical records indicated the injured worker (IW) was treated for pain in joint of lower leg; chronic pain syndrome. According to the progress notes (4-24-15), the IW reported abdominal pain rated 6 out of 10, radiating to the right thigh. Medications were tolerated well with no evidence of dependency. Her pain symptoms were adequately managed. Medications were Cyclobenzaprine (since at least 11-21-13), Tramadol (since at least 11-21-13), Omeprazole, Terocin patch 4-4%, Lidopro 4% ointment and Lidopro 4.5% ointment. She was temporarily totally disabled. On physical examination (4-9-15 and 4-24-15), the IW had an antalgic gait, restricted and painful range of motion in the right hip and tenderness in the right groin. She also had increased pain with lumbar flexion and extension. There was grade 4 muscle strength in the knee and hip in the right lower extremity and grade 5 on the left. There were no sensory deficits. The IW had received physical therapy and completed a functional restoration program. Right hip x-ray on 1-22-15 was negative. A urine drug screening on 1-8-15 was inconsistent with prescribed medications. A Request for Authorization was received for Lidopro ointment 4.5%, #1, Cyclobenzaprine 7.5mg, #60, Tramadol 150mg, #30 and Omeprazole DR 20mg, #60. The Utilization Review on 6-23-15 non-certified the request for Lidopro ointment 4.5%, #1, Cyclobenzaprine 7.5mg, #60, Tramadol 150mg, #30 and Omeprazole DR 20mg, #60, as the treatments were not within the CA MTUS, ACOEM and ODG guideline recommendations.

IMR ISSUES, DECISIONS AND RATIONALES

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

LidoPro ointment 4\$/27.5%/0.0325% cream one tub: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: Per the MTUS, topical analgesics are recommended as an option, they are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Lidocaine is approved for use in the form of a dermal patch. Gels, creams or lotions are not indicated for neuropathic pain and lidocaine is not recommended for non-neuropathic pain. A review of the injured workers medical records that are available to me does not show a trial of recommended first line agents that have failed and there does not appear to be any reason to deviate from the guidelines therefore the request for LidoPro is not medically necessary.

Cyclobenzaprine 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

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

Decision rationale: Per the MTUS, Cyclobenzaprine is recommended as an option in the treatment of chronic pain using a short course of therapy. It is more effective than placebo in the management of back pain; the effect 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. Treatment should be brief. Treatment is not recommended for longer than 2-3 weeks. Therefore, the request for Cyclobenzaprine 7.5mg #60 is not medically necessary.

Tramadol 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The MTUS states that tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Opioids are recommended for chronic pain, especially neuropathic pain that has not responded to first line recommendations like antidepressants and anticonvulsants. Long term users should be reassessed per specific guideline recommendations and the dose should not be lowered if it is working. Per the MTUS, Tramadol is indicated for moderate to severe pain. Per the MTUS, opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances, Opioids should be continued if the patient has returned to work or has improved functioning and pain. Ongoing management actions should include prescriptions from a single practitioner, taken as directed and all prescriptions from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. Documentation 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 maintenance phase, the dose should not be lowered if it is working. In addition, 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. A review of the injured workers medical records do not reveal documentation of improvement in pain and function as well as ongoing management actions as required by the guidelines therefore the request for Tramadol 150mg #30 is not medically necessary.

Omeprazole DR 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. 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. 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. A review of the injured workers medical records that are available to me does not reveal that the injured worker is at risk for a gastrointestinal event therefore the request for Omeprazole DR 20mg #60 is not medically necessary.