

Case Number:	CM15-0076761		
Date Assigned:	04/28/2015	Date of Injury:	01/24/2011
Decision Date:	07/07/2015	UR Denial Date:	03/27/2015
Priority:	Standard	Application Received:	04/22/2015

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: Montana

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 55 year old male injured worker suffered an industrial injury on 01/24/2011. The diagnoses included cervical spine strain, bilateral shoulder sprain with right labral tear and left rotator cuff tear bilateral knee osteoarthritis, bilateral wrist sprain/strain, and lumbar spine spinal stenosis with degenerative disc disease. The diagnostics included multiple x-rays and MRIs. The injured worker had been treated with physical therapy, medications, injections and surgeries. On 3/13/2015 the treating provider reported the left shoulder pain 8/10 and right shoulder pain was 3 to 4/10. The right knee pain 8/ 10 and received a cortisone injections which decreased the pain. There was no change in the 8/10 cervical pain. The treatment plan included Norco, Prilosec, Naproxen, Bilateral knee OA braces, and Internal Medicine consult.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-81 and 91.

Decision rationale: The MTUS states that opioid analgesics are a class of drugs (e.g., morphine, codeine, and methadone) that have a primary indication to relieve symptoms related to pain. Opioid drugs are available in various dosage forms and strengths. They are considered the most powerful class of analgesics that may be used to manage chronic pain. These medications are generally classified according to potency and duration of dosage duration. Norco is a brand name for hydrocodone, a short-acting opioid analgesic, combined with acetaminophen. The MTUS states that opioids are not recommended as first line therapy for neuropathic pain. Opioids are suggested for neuropathic pain that has not responded to first line recommendations including antidepressants and anticonvulsants. For chronic back pain opioids appear to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. (Martell-Annals, 2007) (Chou, 2007) For osteoarthritis opioids are not recommended as a first-line therapy. They are recommended on a trial basis for short-term use after there has been evidence of failure of first-line medication options such as acetaminophen or NSAIDs when there is evidence of moderate to severe pain. Also recommended for a trial if there is evidence of contraindications for use of first-line medications. Under study for long-term use as there is a lack of evidence to allow for a treatment recommendation. If used on a long-term basis, the criteria for use of opioids should be followed. For nociceptive pain they are recommended as the standard of care for treatment of moderate or severe nociceptive pain (defined as pain that is presumed to be maintained by continual injury with the most common example being pain secondary to cancer). For mechanical and compressive etiologies opioids are rarely beneficial. The MTUS states that reasonable alternatives to opioid use should be attempted. There should be a trial of non-opioid analgesics. When subjective complaints do not correlate with clinical studies a second opinion with a pain specialist and a psychological assessment should be obtained. The lowest possible dose should be prescribed to improve pain and function. Ongoing use of hydrocodone/acetaminophen requires review and documentation of pain relief, functional status with documented improvement, appropriate medication use, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. Pain assessment should include: the least reported pain over the period since the last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. In this case the medical records show that the injured worker has been taking Norco on a long term basis. Utilization Reviews noted that there was no documentation of specific functional improvement. Urine drug testing has been performed. Without the additional documentation for ongoing use, as noted above, the request for Norco 5/325mg #60 is not medically necessary.

Prilosec 20mg #30: 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 Non-steroidal anti-inflammatory drugs, GI symptoms and cardiovascular risk Page(s): 68.

Decision rationale: Prilosec (omeprazole) is a proton pump inhibitor. Proton pump inhibitors and H2 receptor antagonists are frequently used for gastrointestinal symptoms related to use of non-steroidal anti-inflammatory medication. The MTUS notes that 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 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). Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. The ODG guidelines recommend proton pump inhibitor for patients at risk for gastrointestinal events. 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. If a PPI is used, omeprazole OTC tablets or lansoprazole 24HR OTC are recommended for an equivalent clinical efficacy and significant cost savings. Research, all of the commercially available PPIs appeared to be similarly effective. (AHRQ, 2011) In this case the treatment records do not document gastrointestinal complaints related to use of NSAIDs or other medications. The Utilization Review on 3/27/15 noted that, without certification of the oral NSAID, there was no indication for use of Prilosec. Naproxen sodium is determined to be not medically necessary due to no documentation of efficacy. Without specific GI complaints and indication noted in the treatment records the request for Prilosec 20mg #30 is not medically necessary.

Naproxen 550mg #60 x 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs Page(s): 67-68 and 73.

Decision rationale: Naproxen is a non-steroidal anti-inflammatory drug (NSAID). The MTUS states that non-steroidal anti-inflammatory medications are recommended at the lowest dose for the shortest period possible in patients with moderate to severe pain. Although NSAIDs are effective they can cause gastrointestinal irritation or ulceration. Studies also show that NSAID use for more than a few weeks can retard or impair bone, muscle, and connective tissue healing and may cause hypertension. For osteoarthritis (including knee and hip) 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. (Chen, 2008) (Laine, 2008) For chronic low back pain NSAIDs are recommended as an option for short-term symptomatic relief. Regarding neuropathic pain, the guidelines note inconsistent evidence for the use of these medications to treat long-term neuropathic pain but they may be useful to treat breakthrough pain. Naproxen as sodium salt is available in 550 mg (Anaprox). In this case the medical records note that naproxen sodium had been certified by Utilization Review on 10/27/14. Subsequent medical records do not demonstrate substantial pain relief and functional

improvement related to use of naproxen sodium and there is no documentation of side effects, including GI complaints. Without documentation of efficacy and functional improvement, the request for ongoing treatment with naproxen sodium 550 mg #60, with 1 refill is not consistent with the MTUS recommendations and is not medically necessary.

Bilateral knee OA braces for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346. Decision based on Non-MTUS Citation Bilateral knee OA braces for purchase, knee, knee braces.

Decision rationale: The MTUS states that functional bracing is optional as part of a rehabilitation program. The ODG guidelines note the following Criteria for the use of knee braces: Prefabricated knee braces may be appropriate in patients with one of the following conditions: 1. Knee instability. 2. Ligament insufficiency/deficiency. 3. Reconstructed ligament. 4. Articular defect repair. 5. Avascular necrosis. 6. Meniscal cartilage repair. 7. Painful failed total knee arthroplasty. 8. Painful high tibial osteotomy. 9. Painful unicompartmental osteoarthritis. 10. Tibial plateau fracture Custom-fabricated knee braces may be appropriate for patients with the following conditions which may preclude the use of a prefabricated model: 1. Abnormal limb contour, such as: a. Valgus [knock-kneed] limb. b. Varus [bow-legged] limb. c. Tibial varum. d. Disproportionate thigh and calf (e.g., large thigh and small calf). e. Minimal muscle mass on which to suspend a brace. 2. Skin changes, such as: a. Excessive redundant soft skin. b. Thin skin with risk of breakdown (e.g., chronic steroid use). 3. Severe osteoarthritis (grade III or IV). 4. Maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain). 5. Severe instability as noted on physical examination of knee. The Utilization Review on 3/27/15 did modify the request to certify OTC purchase of OA knee braces. Subsequent records are not provided that would indicate that the OTC braces are inadequate and custom braces are requested. As such, the request for Bilateral knee OA braces for purchase is not medically necessary.

Internal medicine consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, Independent Medical Examinations and Consultations, page 127.

Decision rationale: The MTUS in the ACOEM guidelines notes that the practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. The consultation service to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. In this case a consultation with an internal medicine specialist is requested for AOE/COE determination. The

Utilization Review on 3/27/15 certified 1 office visit with an internal medicine specialist. It is not clear whether the issue of work relatedness was addressed. Without additional documentation, the request for internal medicine consult is not medically necessary.