

Case Number:	CM15-0090397		
Date Assigned:	05/14/2015	Date of Injury:	09/25/2013
Decision Date:	07/07/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	05/11/2015

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: Indiana

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 32 year old female who sustained an industrial injury on September 25, 2013. She has reported injury to the back, bilateral ankles, and buttock and has been diagnosed with cervical sprain/strain, thoracic sprain/strain, lumbar radiculopathy, lumbar sprain/strain, right ankle pain, left ankle injury, and lesion of sciatic nerve. Treatment has included medications and acupuncture. There was decreased range of motion of the cervical spine with lateral tenderness. There was tenderness to palpation of the thoracic spine with decreased range of motion. There was decreased range of motion to the lumbar spine with tenderness of the paraspinal muscles. There was decreased range of motion to the bilateral ankles. The buttock showed mild tenderness to palpation with increased pain when range of motion was increased. The treatment request included Ranitidine, trigger point injections, epidural steroid injection, cane, and a urinalysis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Ranitidine 150mg, #60, dispensed 3/23/15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation PDR, GI, GERD.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs; GI distress Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk Other Medical Treatment Guideline or Medical Evidence: Uptodate.com, NSAIDs (including aspirin): Primary prevention of gastroduodenal toxicity.

Decision rationale: Ranitidine is an H2 antagonist used for the treatment of stomach ulcers and gastroesophageal reflux. MTUS states, "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)." And "Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g 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 (adjusted odds ratio 1.44)." Uptodate states regarding H2 antagonist for GI prophylaxis, "Standard doses of H2 receptor antagonists were not effective for the prevention of NSAID-induced gastric ulcers in most reports, although they may prevent duodenal ulcers [33]. Studies that detected a benefit on gastric ulcer prevention were short-term (12 to 24 weeks) and focused on endoscopic rather than clinical endpoints." The patient does not meet the age recommendations for increased GI risk. The medical documents provided establish the patient has experienced GI discomfort, but is nonspecific and does not indicate history of peptic ulcer, GI bleeding or perforation. Medical records do not indicate that the patient is on ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID. Additionally, uptodate suggests that H2 antagonist at this dose is not useful for to prevent ulcers. As such, the request for Ranitidine is not medically necessary.

Trigger Point Injections to Cervical Spine X3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections.

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

Decision rationale: MTUS states that Trigger Point Injections are recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain. And further states that "trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band. For fibromyalgia syndrome, trigger points injections have not been proven effective." MTUS lists the criteria for Trigger Points: (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) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief 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) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. The medical documents do meet some criteria for trigger point injections per MTUS. MTUS specifically states that radiculopathy should not be present by exam, imaging, or neuro-testing. However, subjective complaints of radiculopathy are present on numerous treatment notes and in imaging. As such, the request for trigger point injection neck is not medically necessary.

Lumbar Epidural Steroid Injection X 3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections (ESIs), therapeutic.

Decision rationale: MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." There were no medical documents provided to conclude that other rehab efforts or home exercise program is ongoing. Additionally, no objective findings were documented to specify the dermatomal distribution of pain. MTUS further defines the criteria for epidural steroid injections to include: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. Radiculopathy does appear to be documented with imaging studies. The patient is taking multiple medications, but the progress reports do not document how long the patient has been on these medications and the unresponsiveness to the medications. Additionally, treatment notes do not indicate if other conservative treatments were tried and failed (exercises, physical therapy, etc). As such, the request is not medically necessary.

Cane: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Walking Aids.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Knee; Walking Aids.

Decision rationale: Concerning canes, ODG states: "Recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. (Van der Esch, 2003) There is evidence that a brace has additional beneficial effect for knee osteoarthritis compared with medical treatment alone, a laterally wedged insole (orthosis) decreases NSAID intake compared with a neutral insole, patient compliance is better in the laterally wedged insole compared with a neutral insole, and a strapped insole has more adverse effects than a lateral wedge insole. (Brouwer-Cochrane, 2005) Contralateral cane placement is the most efficacious for persons with knee osteoarthritis. In fact, no cane use may be preferable to ipsilateral cane usage as the latter resulted in the highest knee moments of force, a situation which may exacerbate pain and deformity. (Chan, 2005) While recommended for therapeutic use, braces are not necessarily recommended for prevention of injury. (Yang, 2005) Bracing after anterior cruciate ligament reconstruction is expensive and is not proven to prevent injuries or influence outcomes. (McDevitt, 2004) Recommended, as indicated below. Assistive devices for ambulation can reduce pain associated with OA. Frames or wheeled walkers are preferable for patients with bilateral disease. (Zhang, 2008) While foot orthoses are superior to flat inserts for patellofemoral pain, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. (Collins, 2008) In patients with OA, the use of a cane or walking stick in the hand contralateral to the symptomatic knee reduces the peak knee adduction moment by 10%. Patients must be careful not to use their cane in the hand on the same side as the symptomatic leg, as this technique can actually increase the knee adduction moment. Using a cane in the hand contralateral to the symptomatic knee might shift the body's center of mass towards the affected limb, thereby reducing the medially directed ground reaction force, in a similar way as that achieved with the lateral trunk lean strategy described above. Cane use, in conjunction with a slow walking speed, lowers the ground reaction force, and decreases the biomechanical load experienced by the lower limb. The use of a cane and walking slowly could be simple and effective intervention strategies for patients with OA. In a similar manner to which cane use unloads the limb, weight loss also decreases load in the limb to a certain extent and should be considered as a long-term strategy, especially for overweight individuals." The employee meets the above criteria for a cane, and thus, the request is medically necessary.

Urine Analysis: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug screen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; testing for substance abuse Page(s): 74-109. Decision based on Non-MTUS Citation University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009), pg 32 Established Patients Using a Controlled Substance.

Decision rationale: MTUS states that use of urine drug screening for illegal drugs should be considered before therapeutic trial of opioids are initiated. Additionally, "Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion) would indicate need for urine drug screening. There is insufficient documentation provided to suggest issues of abuse, addiction, or poor pain control by the treating physician. University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009) recommends for stable patients without red flags twice yearly urine drug screening for all chronic non-malignant pain patients receiving opioids once during January-June and another July-December." The patient has been on chronic opioid therapy. The treating physician has not indicated why a urine drug screen is necessary at this time and has provided no evidence of red flags. As such, the request is not medically necessary.