MAXIMUS Federal Services

Case Number:	CM15-0126814		
Date Assigned:	07/13/2015	Date of Injury:	06/15/2007
Decision Date:	10/14/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	06/30/2015

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: New York
Certification(s)/Specialty: Pediatrics, 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:

The injured worker is a 57 year old female, who sustained an industrial injury on 06/15/2007. She reported pain in her right upper extremity, shoulder and low back. Diagnoses included cervical myofascial strain with radicular complaints, lumbar myofascial strain with radicular complaints, right shoulder and parascapular strain, right wrist and hand strain with de Quervain's tenosynovitis and right thumb basilar arthropathy. On 04/13/2015, subjective complaints included low back pain and stiffness with pain, numbness and tingling extending down the right lower extremity to the foot, neck pain and stiffness, right shoulder pain with pain, numbness and tingling extending down the right extremity to the fingers and gastrointestinal distress secondary to all of the above. According to a partially legible handwritten progress report dated 05/28/2015, primary complaints included low back pain with radiation to the right lower extremity with numbness and tingling to the foot increased with lifting/bending/stooping. Pain level was rated 7-8 on a scale of 0-10. Objective findings included pain at right sciatic notch, decreased range of motion, positive straight leg raise/right, increased low back pain/left. Authorization for physical therapy was pending. Current medications included Ultram, Prilosec and Voltaren 75 mg. Pain level with medications was rated 3-4 and without medications was 7-8. The injured worker was to return to work with work restrictions. X-ray of the lumbar spine was obtained and showed spurring L3-S1. The radiology report was not submitted for review. The provider noted consideration with pain management-epidural steroid injection. Prescriptions included Diclofenac ER 100 mg, Omeprazole 20 mg and Tramadol 50 mg. Currently under review is the request for Voltaren XR 100 mg #30, Prilosec 20 mg #30 and MRI of the lumbar spine. Documentation submitted for review shows the use of Diclofenac sodium by the injured worker, dating back to 02/03/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren XR 100mg #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): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, specific drug list & adverse effects. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Anti-inflammatories, NSAIDS, Diclofenac.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. MTUS Guidelines state that NSAIDS (non-steroidal anti-inflammatory drugs) are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. MTUS specific recommendations for NSAIDs include treatment of osteoarthritis for the shortest time possible and short term treatment of back pain. It may be useful for breakthrough and mixed pain conditions in patients with neuropathic pain. Other chronic pain conditions are not discussed. ODG states that anti-inflammatories are the traditional first line of treatment to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. ODG specific recommendations for NSAIDS (non-steroidal anti-inflammatory drugs) include treatment of osteoarthritis for the shortest period in patients with moderate to severe pain, for treatment in acute low back pain & acute exacerbations of chronic pain and short-term symptomatic relief of chronic low back pain. ODG Guidelines state that Diclofenac is not recommended as first line due to increased risk profile. A large systematic review of available evidence on NSAIDs confirms that Diclofenac, a widely used NSAID, poses an equivalent risk for cardiovascular events to patients as did rofecoxib (Vioxx), which was taken off the market. According to the authors, this is a significant issue and doctors should avoid Diclofenac because it increases the risk by about 40%. For a patient who has a 5% to 10% risk of having a heart attack, that is a significant increase in absolute risk, particularly if there are other drugs that don't seem to have that risk. For people at very low risk, it may be an option. In this case, the injured worker has been using Diclofenac dating back to 02/03/2015. Long term use is not recommended. There is a lack of functional improvement with the treatment already provided. Documentation did not show sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care with use of Diclofenac. Guidelines do not recommend Diclofenac as a first-line agent. There was no discussion of trial and failure with first line agents. Medical necessity for the requested treatment is not established. The requested treatment is not medically necessary.

Prilosec 20mg #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): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Proton Pump Inhibitors.

Decision rationale: According to the California MTUS (2009), Omeprazole (Prilosec), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, at risk for gastrointestinal events. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. Official Disability Guidelines (ODG) states that proton pump inhibitors are recommended for patients at risk for gastrointestinal events. Decision to use proton pump inhibitors long-term must be weighed against the risks. The potential adverse effects of long-term proton pump inhibitor use included B12 deficiency, iron deficiency, hypomagnesemia, increased susceptibility to pneumonia, enteric infection and fractures, hypergastrinemia and cancer and more recently adverse cardiovascular effects. Proton pump inhibitors have a negative effect on vascular function, increasing the risk for myocardial infarction. Patients with gastroesophageal reflux disease on proton pump inhibitors had a 1.16 greater risk of myocardial infarction and a 2.00 risk for cardiovascular mortality. Proton pump usage may be serving as a marker for a sicker population, but this is unlikely, given the lack of increased risk seen in patients taking H2 blockers. (Shah, 2015) In this study proton pump inhibitor use was associated with a 1.58 fold greater risk of myocardial infarction and in the case-crossover study, adjusted odds ratios of proton pump inhibitor for myocardial risk were 4.61 for the 7 day window and 3.47 for the 14 day window. However, the benefits of proton pump inhibitors may greatly outweigh the risks of adverse cardiovascular effects, with number needed to harm of 4357. (Shih, 2014) Outpatient proton pump use is associated with a 1.5 fold increased risk of community-acquired pneumonia, with the highest risk within the first 30 days after initiation of therapy. (Lamber, 2015) The updated Beers Criteria, which help prevent adverse drug events in older adults, added a recommendation to avoid the use of proton pump inhibitors for more than 8 weeks, except for long-term NSAID users and patients with erosive esophagitis, Barrett's esophagitis, pathologic hypersecretory condition, or a demonstrated need for maintenance therapy. There are many studies demonstrating, in elderly patients, an increased risk for Clostridium difficile infection and bones loss and fractures with the long-term use of proton pump inhibitors. (AGS, 2015) In this case, Diclofenac (an NSAID) was found to be not medically necessary. Documentation did not show gastrointestinal risk factors as indicated per MTUS Guidelines. Medical necessity for the requested treatment is not established. The requested treatment is not medically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: According to ACOEM guidelines CT or MRI are indicated if there are red flags for cauda equina, tumor, infection, or fracture when plain films are negative and MRI is the test of choice for patients with prior back surgery. There was no documentation of concern for the above issues and the IW had no previous history of back surgery. The request is not medically necessary.