

<b>Case Number:</b>	CM13-0046973		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	09/11/2001
<b>Decision Date:</b>	04/18/2014	<b>UR Denial Date:</b>	10/28/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2013

### 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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 51 year old male who was injured on 09/11/2001. Mechanism of injury is unknown. Prior treatment history has included physiotherapy, lumbar epidural injection. Medications include Norco 10/325 mg, Anaprox DS 550 mg, and Prilosec 20 mg. Diagnostic studies reviewed included provocative discogram dated 02/20/2006 was unequivocally negative at L2-3 and L3-4. A post discogram CT scan did not show any evidence of an annular tear. An MRI of the lumbar spine dated 06/12/2008 with and without contrast did not reveal any surgical abnormalities at all. There was a 2mm right intraforaminal/extraforaminal disc protrusion at L1-2 and L2-3 but was without foraminal or central stenosis. Electrodiagnostic study dated 06/13/2008 reveals a left L4 and bilateral L5 and S1 nerve root impingement being moderate to severe on the right at L5. An L3-4 facet injection dated 09/16/2009 provided almost complete pain relief for three or four days. A hardware block at bilateral L4-L5 and S1 gave almost complete pain relief for three to four days. MRI of the lumbar spine dated 01/18/2010 revealed status post prior fusion at L4-5 and L5-S1 with evidence of an anterior fusion. There are no significant bulges or neural foraminal stenosis. Facet hypertrophy is noted at L3-4. An MRI of the lumbar spine dated 03/16/2011 reveals posterior laminectomy and discectomy from L3 down to the sacrum as well as retained metal at L3 and L4 bilaterally. The bone fusion mass appears solid. There are some hypertrophic changes at the facet joints. MRI of the lumbar spine performed 03/21/2013 revealed the following: 1. 1. Posterior decompression with interbody fusion at L3-4, L4-5, and L5-S1. A large fluid collection is present within the laminectomy site compatible with seroma versus pseudomeningocele. 2. 2. L1-2, a 3.5 mm anterior disc bulge is noted. 3. 3. L2-3, bilateral facetarthrosis and ligamentum hypertrophy are noted. 4. 4. L4-5, bilateral facet hypertrophy which produces marked bilateral neural foraminal narrowing. 5. 5. L5-S1, bilateral facet hypertrophy which produces marked bilateral neural foraminal narrowing.

A urine drug screen performed on 09/20/2013 revealed inconsistency with prescription therapy and detected Cyclobenzaprine, hydrocodone and hydromorphone. Urine drug screen performed 11/20/2013 was positive for hydrocodone. Pain management consultation dated 10/02/2013 documented the patient to have complaints of pain in the low lumbar region with some radicular symptoms which correlate with his last electrodiagnostic study which reveals bilateral radiculopathies, right greater than left. Objective findings on exam included examination of the lumbar spine revealed posterior lumbar musculature with tenderness to palpation bilaterally with increased muscle rigidity. There are numerous trigger points which are palpable and tender throughout the lumbar paraspinal muscles. The patient has decreased range of motion with obvious muscle guarding. There is a well healed scar noted. Lumbar spine range of motion shows flexion 60 degrees, extension 25 degrees, left lateral bend 25 degrees and right lateral bend 25 degrees. Neurological examination revealed deep tendon reflexes on patellae on right 2/4 bilaterally and Achilles tendon 1/4 bilaterally. Lower extremity motor testing was 4-4+/5 bilaterally in all muscle groups. Sensory examination to Wartenberg pinprick wheel is decreased along the posterior lateral thigh, posterior lateral calf bilaterally, and dorsum of the right foot. Straight leg raise in the modified sitting is positive/negative at 65 degrees bilaterally. Pharmacological assessment and management: Norco 10/325 mg, 6-8 tablets qid, Anaprox DS 550 mg bid, and topical analgesic cream. PR-2 dated 11/20/2013 documented the patient with complaints of significant muscle spasm. The benefits of the lumbar epidural steroid injection performed on 06/18/2013 starting to wear off. Objective findings on exam reveals the patient moves slowly in and out of the office and has somewhat of an antalgic gait favoring the right leg. Examination of the lumbar spine reveals posterior lumbar musculature with tenderness to palpation bilaterally with increase muscle rigidity. There are numerous trigger points which are palpable and tender throughout the lumbar paraspinal muscles. The patient has decreased range of motion with obvious muscle guarding. There is a well healed scar noted. Lumbar range of motion has flexion at 60 degrees, extension 23 degrees, left lateral bend 25 degrees and right lateral bend at 25 degrees. Deep tendon reflexes at patellae is 2/4 bilaterally and 1/4 bilaterally at Achilles tendon. Lower extremity motor testing was 4-4+/5 bilaterally in all muscle groups. Sensory examination to Wartenberg pinprick wheel is decreased along the posterior lateral thigh, posterior lateral calf bilaterally, and dorsum of the right foot. Straight leg raise in the modified sitting is positive/negative at 65 degrees bilaterally. Assessment: 1. 1. S/p anterior posterior instrumentation and fusion at L4-5 and L5-S1, 07/07/2003. 2. 2. Status post lumbar interbody fusion, L3-4, with removal of posterior hardware L4-5 and L5-S1 01/26/2010 with subsequent removal of retained metal L3-4 October 2011. 3. 3. Bilateral lower extremity radiculopathy. 4. 4. Medication induced gastritis. Treatment Plan: Patient was dispensed Norco 10/325 mg #180, Anaprox DS #60 and Prilosec 20 mg #60.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**ANAPROX DS 550MG #60:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs  
Page(s): 67-68.

**Decision rationale:** According to the guidelines, NSAIDS are recommended as an option for short-term symptomatic relief of chronic low back pain. Given the documented subjective complaints and objective findings, it is reasonable that the patient be provided with a non-steroidal anti-inflammatory to provide symptomatic relief of mild to moderate pain. The medical records document the patient has been using this medication, and there is no documented issue of side-effects with use. This request is supported by the reference guidelines. A one-month supply of Anaprox 550 #60 is deemed appropriate and medically necessary.

**PRILOSEC 20MG #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI SYMPTOMS & CARDIOVASCULAR RISK.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms & cardiovascular risk, Page 68.

**Decision rationale:** Recommend with precautions as indicated below.

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). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease :(1) A nonselective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 µg 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). It is acknowledged that the 11/20/2013 PR-2 includes a diagnosis of medication induced gastritis. However, the medical records do not document a subjective complaint or correlated history supporting this diagnosis. Additionally, the medical records do not substantiate this patient is considered at risk for gastrointestinal events secondary to NSAID use, as outlined in the guideline referenced above. In the absence of these findings, or substantiation that the patient has such risk factors as set forth by the evidence-based guidelines, the medical necessity for Prilosec is not established.

