

Case Number:	CM14-0158171		
Date Assigned:	10/01/2014	Date of Injury:	04/10/2014
Decision Date:	11/19/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/26/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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:

Patient is a 74-year-old woman who sustained a work-related injury on April 10, 2014. Subsequently, she developed with the left upper extremity pain. Her physical examination demonstrated the mild pain with deep palpation over the dorsum of the left wrist. There was a positive deQuervain's sign. The rest of her physical examination was normal. Her ultrasound of the left wrist performed on May 6 2014 demonstrated soft tissue swelling. The patient was treated with the cortisone injection to the first dorsal compartment of the left thumb, a thumb brace, Anaprox, Prilosec, Vicodin, ibuprofen and hydrocodone for pain relief. According to a documented dated on June 23, 2014, the patient was taking medications with some success. The patient was diagnosed with the tenosynovitis, left wrist sprain and dorsal tenosynovitis. The provider request authorization to use the medications mentioned below.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Prilosec 20mg #60 DOS: 6/23/14 to 6/23/14: Upheld

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

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

Decision rationale: According to MTUS guidelines, Omeprazole is indicated when NSAID are used in patients with intermediate or high risk for gastrointestinal events. The risk for gastrointestinal events are: (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 NSAID to develop gastroduodenal lesions. There is no documentation that the patient has GI issue that requires the use of prilosec. There is no documentation in the patient's chart supporting that he is at intermediate or high risk for developing gastrointestinal events. Therefore, Retrospective Prilosec 20mg #60 DOS: 6/23/14 to 6/23/14 is not medically necessary.

Retrospective Vicodin 2.5/235mg #90 DOS: 6/23/14 to 6/23/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79..

Decision rationale: According to MTUS guidelines, ongoing use of opioids should follow specific rules:<(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status,appropriate medication use, and side effects. Pain assessment should include: currentpain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework>Vicodin is a short acting opioid recommended for a short period of time in case of a break through pain or in combination with long acting medications in case of chronic pain. There is no clear evidence of a break though of wrist pain. There is no documentation of patient compliance with pain medications, risk assessment and pain and functional improvement with previous use of opioids. Therefore, the request for Retrospective Vicodin 2.5/235mg #90 DOS: 6/23/14 to 6/23/14 is not medically necessary.

Retrospective Anaprox 550mg #90 DOS: 6/23/14 to 6/23/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Guidelines NON SELECTIVE NSAIDS Page(s): 72..

Decision rationale: Naproxen (Naprosyn): delayed release (EC-Naprosyn), as Sodium salt (Anaprox, Anaprox DS, Aleve [otc]) Generic available; extended-release (Naprelan): 375 mg. Different dose strengths and formulations of the drug are not necessarily bioequivalent. Dosing Information: Osteoarthritis or ankylosing spondylitis: Dividing the daily dose into 3 doses versus 2 doses for immediate-release and delayed-release formulations generally does not affect response. Morning and evening doses do not have to be equal in size. The dose may be increased to 1500 mg/day of naproxen for limited periods when a higher level of analgesic/anti-inflammatory activity is required (for up to 6 months). Naprosyn or naproxen: 250-500 mg PO twice daily. Anaprox: 275-550 mg PO twice daily. (Total dose may be increased to 1650 mg a day for limited periods). EC-Naprosyn: 375 mg or 500 mg twice daily. The tablet should not be broken, crushed or chewed to maintain integrity of the enteric coating. Naprelan: Two 375 mg tablets (750 mg) PO once daily or two 500 mg tablets (1000 mg) once daily. If required (and a lower dose was tolerated) Naprelan can be increased to 1500 mg once daily for limited periods (when higher analgesia is required). Pain: Naprosyn or naproxen: 250-500 mg PO twice daily. The maximum dose on day one should not exceed 1250 mg and 1000 mg on subsequent days. Anaprox: 275-550 mg PO twice daily. The maximum dose on day one should not exceed 1375 mg and 1100 mg on subsequent days. Extended-release Naprelan: Not recommended due to delay in absorption. (Naprelan Package Insert) There is no documentation of the rationale behind using Anaprox. NSAID should be used for the shortest duration and the lowest dose. There is no documentation from the patient file that the provider titrated Anaprox to the lowest effective dose and used it for the shortest period possible. Furthermore, there is no documentation that the provider followed the patient for NSAID adverse reactions that are not limited to GI side effect, but also may affect the renal function. There is no documentation that the patient developed arthritis pain that justify continuous use of Anaprox. There is no documentation of pain and functional improvement of previous use of Anaprox. Therefore, the request for Anaprox is not medically necessary.