

Case Number:	CM14-0173455		
Date Assigned:	10/24/2014	Date of Injury:	11/13/2002
Decision Date:	12/03/2014	UR Denial Date:	10/15/2014
Priority:	Standard	Application Received:	10/21/2014

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:

The patient is a 50-year-old woman who sustained a work-related injury on November 12, 2002. Subsequently, she developed chronic knees, and back pain. The patient underwent anterior cervical fusion of C4-5, C5-6, and C6-7 on January 0f 2005. On July 27, 2006, the patient had a cervical epidural injection C6-7 under fluoroscopy, right greater occipital nerve block, left greater occipital nerve block, and lumbar trigger point injections. On February 19, 2007 she had Botulinum 300 units, with good results. She did also get a series of intra-corticodteroid injctions and synvisc injections to the left knee, which did provide short term benefit. MRI of the left knee done on November 13, 2012 showed medial and lateral tibiofemoral arthrosis and patellofemoral arthrosis. MRI of the right knee performed on November 13, 2012 was normal. X-ray of the right ankle performed on March 8, 2011 showed no obvious fractures or dislocations. MRI of the cervical spine performed on February 28, 2006 documented multilevel posterior changes with discectomy, interbody fusion, and interior and internal fixation at C4 through C7, negative for stenosis or foraminal encroachment. There were peri-operative changes related to the discectomy, but no evidence of recurring disc protrusion or bulging. According to the progress report dated June 20, 2014, the patient continued to complain of debilitating pain in her left knee, which alters her gait and often causes exacerbation of her low back pain. The patient received certification for plasma rich protein injection but was unable to schedule it. Due to her altered gait from her left knee pain, she has been experiencing increased pain in her lower back. She continued to wear her left knee brace a long with a lumbosacral orthosis but has been experiencing increased flare up of her low back pain. She rated the pain in her lower back as a 7/10. The patient had an antalgic gait favoring the right lower extremity. Examination of the cervical spine revealed tenderness to palpation along the posterior cervical musculature bilaterally. There were trigger points that were palpable and tender along the upper trapezius

muscles, medial scapular regions, and suboccipital regions bilaterally. She had significant decrease in range of motion. She was able to bend her neck forward with her chin to about 3 fingerbreadths from sternum; extension was limited to only 10 degrees. She had pain with both maneuvers. She had decreased sensation along the lateral forearm bilaterally as well as along the second, third, and fourth digits bilaterally with the use of Wartenberg pinwheel. There was positive Tinel's on the ventral aspect of the wrist bilaterally, as well as positive Tinel's at the level of the elbow bilaterally. There is thenar and hypothenar muscle atrophy noted as well. Examination of bilateral knees revealed soft tissue swelling with tenderness to palpation along the right lateral ankle. She had decreased range of motion with ankle dorsiflexion and plantar flexion due to pain. The patient was diagnosed with cervical post-laminectomy syndrome, thoracic spine sprain/strain syndrome, lumbar spine sprain/strain syndrome, severe reactionary depression/anxiety, myofascial pain, mild cervical dystonia, cervicogenic headaches, bilateral knee internal derangement, bilateral elbow internal derangement, and medication-induced gastritis. The provider requested authorization to use Norco, Anaprox, and Fexmid.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Norco 10/325mg Quantity: 120 (DOS 9/9/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

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, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and 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. 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>According to the patient file, there is no objective documentation of pain and functional improvement to justify continuous use of Norco. Norco was used for longtime without documentation of functional improvement or evidence of return to work or improvement of activity of daily living. Therefore, the prescription of Norco 10/325 mg, #120 is not medically necessary.

Retrospective request for Anaprox DS 550mg Quantity: 60 (DOS 9/9/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment 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.

Retrospective request for Fexmid 7.5mg Quantity: 60 (DOS 9/9/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41.

Decision rationale: According to MTUS guidelines, a non sedating muscle relaxant is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient in this case does not have clear evidence of acute exacerbation of chronic back pain and spasm and the prolonged use of Fexmid 7.5mg is not

justified. Evidence based guidelines do not recommend its use for more than 2-3 weeks. The request is not medically necessary.