

Case Number:	CM14-0032946		
Date Assigned:	06/20/2014	Date of Injury:	08/31/2013
Decision Date:	07/18/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/14/2014

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:

A 42-year-old patient who sustained a work-related injury to the right wrist on August 31, 2013. Subsequently, the patient developed chronic right wrist pain. According to a note dated on October 9, 2013, the patient's physical examination was remarkable for diffuse tenderness of the entire distal radius, wrist, and carpus with some limitation of motion but negative provocative tests for carpal tunnel syndrome (CTS). Past medical history (PMH) was remarkable. The diagnosis was status post (s/p) contusion/straining injury right hand/wrist. Magnetic resonance imaging (MRI) of the right hand performed on December 24, 2013 was completely normal. A progress report dated on February 10, 2014 noted that the patient's physical examination remained unchanged with continued diffuse tenderness about the entire distal radius, wrist, and carpus. Diagnosis was unchanged. The patient's treatment included: the use of a wrist splint; Norco, Naprosyn, and Protonix and chiropractic therapy. The patient was approved for 12 chiropractic sessions. Although the provider reported some improvement of her condition there is no objective quantification of her pain and her functional improvement. The patient was using Narosyn and Norco on continuous basis for several months without objective documentation of significant benefit. The provider requested authorization to continue the medications mentioned above.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continue Chiropractic; twice a week for six weeks (2x6): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: According to MTUS guidelines, manual therapy "Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion". "Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks ". According to the patient file, there is no documentation of any quantitative decrease in pain severity, no change in the patient's examination findings, and no change in the need for the multiple medications with previous chiropractic sessions. In addition, there is no documentation that there was any significant change/improvement in ADLs or any functional improvement. Therefore, the request for chiropractic visits 2 times a week for 6 weeks is not medically necessary.

Anaprox 550 mg #60: 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 Naproxyn for limited periods when a higher level of analgesic/anti-inflammatory activity is required (for up to 6 months). Naprosyn or Naproxyn: 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 Naproxyn: 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 the long-term use of Naprosyn. NSAID should be used for the shortest duration and the lowest dose. There is no documentation from the patient file that the provider titrated Naprosyn to the lowest effective dose and used it for the shortest period possible. Naprosyn was used at least for 4 months continuously without clear documentation of its efficacy. There is objective documentation of pain and functional improvement with continuous use of 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 and blood pressure. In addition, there is no recent documentation of acute pain exacerbation that may justify the use of Naprosyn. Therefore, the request for Naprosyn 500MG #60 is not medically necessary.

Prilosec 20 mg #30: 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 Treatment 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 risks for gastrointestinal events are: (1) age greater than 65 years; (2) history of peptic ulcer, gastrointestinal (GI) bleeding or perforation; (3) concurrent use of aspirin (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. The patient was not certified to continue Anaprox and 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 the patient is at intermediate or high risk for developing gastrointestinal events. Therefore, Prilosec 20mg#30 prescription is not medically necessary.

Norco 2.5 mg #60: 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): 179.

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 education use, and side effects. Pain assessment should include current pain; 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 four 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." There is no clear evidence of objective and recent functional and pain improvement with previous use of opioids (Norco). There is no clear documentation of the efficacy/safety of previous use of Norco. There is no clear justification for the need to continue the use of Norco. Therefore, the prescription of Norco 2.5 mg #60 is not medically necessary at this time.