

Case Number:	CM13-0030806		
Date Assigned:	01/22/2014	Date of Injury:	08/01/1993
Decision Date:	02/04/2015	UR Denial Date:	09/19/2013
Priority:	Standard	Application Received:	10/01/2013

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 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 53-year-old man who sustained a work related injury on August 1, 1993. Subsequently, he developed low back and neck pain. The patient had epidural steroid injections that were 4-6 months of 50% or greater pain relief. According to a progress report dated September 20, 2013, the patient reported that his cervical spine has been bothering him more and more, as well as the radicular symptoms radiating into the upper extremities. The patient's previous EMG/NCV study revealed a right C6 nerve root irritation and possible bilateral C8, T1 cervical radiculopathy. Examination of the cervical spine revealed tenderness to palpation along the posterior cervical musculature bilaterally with decreased range of motion. He was able to bend his neck forward and extension was limited to about 20 degrees. He had significant muscle rigidity along the cervical musculature, upper trapezius, and medial scapular regions. Examination of the bilateral upper extremities revealed decreased sensation with Wartenberg pinwheel along the lateral arm and forearm bilaterally. the patient also had Tinel's along the ulnar groove bilaterally as well as along the left wrist. He had diffuse muscle atrophy along the thenar and hypothenar muscles bilaterally. There was profound loss of sensation in the ulnar nerve distribution from the wrist proximal and distal. Examination of the lumbar spine revealed tenderness to palpation along the lumbar musculature bilaterally with increased muscle rigidity. He had decreased range of motion but able to forward flex and extension was limited to 10 degrees. He had pain with both maneuvers, but worse with flexion. He had decreased sensation along the L5 distribution bilaterally. Straight leg raise performed in the modified sitting position was positive on the left at 60 degrees and on the right side at about 45 degrees. The patient was diagnosed with cervical degenerative disc disease with facet arthropathy and bilateral upper extremity radiculopathy, thoracic spine sprain/strain syndrome, lumbar degenerative disc disease with facet arthropathy and foraminal narrowing and associated bilateral lower extremity

radiculopathy, bilateral peroneal neuropathy, bilateral knee internal derangement, reactionary depression/anxiety, and medication induced gastritis. The provider requested authorization for Anaprox, Fexmid, and Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox 550mg, 1 tablet bid: Upheld

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

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 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 550mg, 1 tablet bid is not medically necessary.

Fexmid 7.5mg, bid: Upheld

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

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

Decision rationale: According to MTUS guidelines, non-sedating muscle relaxants are 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.

Norco 10/325, 8-10 tablets per day: Upheld

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

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 a long time without documentation of functional improvement or evidence of improvement of activity of daily living. Therefore, the prescription of Norco 10/325, 8-10 tablets per day is not medically necessary.