

<b>Case Number:</b>	CM14-0163615		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	03/19/2013
<b>Decision Date:</b>	02/10/2015	<b>UR Denial Date:</b>	09/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2014

### 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 th

### 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 48-year-old woman who sustained a work related injury on March 19, 2013. Subsequently, she developed a chronic neck, shoulder, arm, and low back pain. According to the orthopedic re-evaluation report dated September 2, 2014, the patient complained of continued pain and stiffness in her cervical spine radiating down the arms and legs, with numbness and weakness to the upper extremities. The patient complained of persistent pain and stiffness to her left shoulder. She complained of ongoing pain to her lumbar spine radiating down the legs. She also complained of persistent and increasing pain of the left knee and complained of depression, anxiety, and difficulty sleeping as well. Examination of the cervical spine and lumbar spine remained essentially unchanged from that of the last visit. Examination of the left shoulder revealed tenderness to palpation over the acromion and the supraspinatus tendon. Impingement and drop arm testing was positive on the left. Range of motion was limited by pain. Examination of the wrists and hands revealed tenderness to palpation over the volar aspects of both wrists. Tinel's and Phalen's testing was positive, bilaterally. There was decreased sensation in the median nerve distributions of both upper extremities. Range of motion of the wrists was within normal range. Motor power was Grade 4/5 in both upper extremities. Sensory response over the C5, C6, and C7 nerve roots was decreased on both the right and left sides. The biceps, triceps, and brachioradialis reflexes were normal and equal, bilaterally. The examination of the left knee revealed significant tenderness to palpation over the medial and lateral joint lines and patellofemoral joint. There was pain to varus and valgus stressing, but no gross instability was noted. McMurray and revers McMurray testing was positive on the left. Range of motion of the left knee remained limited. Sensation remained decreased to light touch and pinprick in the left L4, L5, and S1 dermatomes. MRI of the cervical spine dated December 12, 2013 showed a 4 mm broad annular bulge at C5-6 slightly more prominent on the left with mild left anterior impingement of the cord and mild to moderate bilateral foraminal narrowing with minimal

annular bulge at C6-7. EMG/NCV study of the upper extremities performed on July 24, 2014 documented severe bilateral carpal tunnel syndrome and acute bilateral C5, C6, and C7 radiculopathy. The patient was diagnosed with cervical spine sprain/strain, symptomatic disc protrusion at C5-6, bilateral C5, C6, and C7 radiculopathy, tendinitis/impingement syndrome of the left shoulder, lumbar spine sprain/strain, symptomatic disc protrusion at L4-5, medial and lateral meniscal tears of the left knee, and left knee tricompartmental cartilage loss. The provider requested authorization for Naproxen and Ultram.

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

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

**Naproxen 550mg 1 BID #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) and NSAIDS, specific drug list & adverse effects, page 67, 68 and 73.

**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 Naproxen. NSAID should be used for the shortest duration and the lowest dose. There is no documentation from the patient file that the provider titrated Naproxen to the lowest effective dose and used it for the shortest period possible. Naproxen was used without clear documentation of its efficacy. 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. Therefore, the request for Naproxen 550 mg #60 is not medically necessary.

**Ultram 50mg 1 BID #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Weaning of Medications; and Opioids, specific drug list, page 76-80, 124, and 93-94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113.

**Decision rationale:** According to MTUS guidelines, Ultram (Tramadol) 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. Although, Tramadol may be needed to help with the patient pain, there is no clear evidence of objective and recent functional and pain improvement from its previous use. There is no clear documentation of the efficacy/safety of previous use of tramadol. There is no recent evidence of objective monitoring of compliance of the patient with her medications. Therefore, the prescription of Ultram 50mg #60 is not medically necessary.