MAXIMUS Federal Services

Case Number:	CM15-0139589		
Date Assigned:	07/29/2015	Date of Injury:	02/27/2006
Decision Date:	08/28/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/20/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Iowa, Illinois, Hawaii
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 injured worker is a 47-year-old male patient who sustained an industrial injury on February 27, 2006. A primary treating office visit dated January 08, 2015 reported the patient requiring escalating doses of the oral analgesic medication due to significant radicular symptoms to the lower extremity. He continues with Norco 10/325mg and takes up to 8 tablets daily along with Roxicodone 30mg 6 tablets daily. He is also prescribed Neurontin, Wellbutrin, Prilosec and Soma. There is a scheduled permanent implantation of an intrathecal infusion pump on January 25, 2015. He does have a known history of multilevel disc disease with positive discogram findings at L4-5 greater than L3-4 and L5- S1. He was at one time considered being a surgical candidate; however, was deemed unstable for surgery secondary to uncontrolled hypertension. In addition, he underwent coronary bypass procedure on November 20, 2012 involving three vessels. Recently he has had multiple falls and near falls with his legs giving out. He relies on a single point cane to ambulate. He even is with complaint of right elbow discomfort secondary to using the cane. Objective findings showed lumbar spine with tenderness to palpation bilaterally with increased muscle rigidity. There are numerous trigger points throughout the paraspinal muscles. He has decreased range of motion with obvious muscle guarding. Sensory examination showed decreased along the posterolateral thigh and posterolateral calf in the left L5-S1 distribution. A straight leg raise in the modified sitting position is positive at 60 degrees causing radicular symptom to bilateral lower extremity. The assessment found the patient with lumbar myoligamentous injury with associated facet joint hypertrophy; herniated nucleus pulposus at L4-5 and L5-S1 with central and foraminal stenosis; left lower extremity radiculopathy; reactionary depression and anxiety; coronary artery disease, status post stents, on Coumadin; uncontrolled severe hypertension; three level positive provocative discography; status post 3 vessels coronary bypass, medication induced gastritis; right lateral epicondylitis

industrial, and hypertension, industrial. There is also note of recent authorization to administer an epidural injection which was held due to bypass surgery. Previous treatment modality to include: numerous oral analgesia, epidural steroid injections, and spinal cord stimulation. He even underwent intrathecal Morphine that offered good pain relief with unbearable side effects. There is physician recommendation to proceed with intrathecal pump as noted with positive trial results. There is also recommendation for an injection to the right lateral epicondyle area. Aqua therapy is also recommended treating the lower back complaints. At a follow up visit, dated June 17, 2015 current medication regiment consisted of OxyContin, Roxicodone, Norco, Neurontin, Clonidine, Minixidil, Soma, LidoPro topical, Anaprox, Prilosec, Prozac, and Xanax.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox DS 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications; NSAIDs, specific drug list & adverse effects Page(s): 22; 70.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Naproxen, NSAIDs (non-steroidal anti- inflammatory drugs).

Decision rationale: MTUS specifies four recommendations regarding NSAID use: 1) Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. 2) Back Pain - Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective that acetaminophen for acute LBP. 3) Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. 4) Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. The treating physician does not document failure of primary (Tylenol) treatment. The treating physician has not provided documentation of an exacerbation of the patient's injury. Guidelines recommend the use of NSAIDs at the lowest effective dose for the shortest length of time; it is unclear how long the patient has been taking Anaprox. Additionally, medical documentation provided indicates NSAID therapy did not effectively treat this patient's low back pain in the past. The rationale behind this request is unclear. As such, the request for Anaprox DS 550mg #60 is not medically necessary.