

Case Number:	CM15-0146705		
Date Assigned:	08/07/2015	Date of Injury:	06/19/2002
Decision Date:	09/04/2015	UR Denial Date:	07/16/2015
Priority:	Standard	Application Received:	07/28/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 66 year old female who sustained an industrial injury on 06/19/2002. The injured worker was diagnosed with chronic pain syndrome, cervical radiculitis, cervical discogenic pain, thoracic and low back pain and myofascial pain. The injured worker is status post anterior cervical fusion from C4-C7 (no date documented). Treatment to date has included diagnostic testing, surgery, acupuncture therapy, physical therapy, topical and oral medications and home exercises. According to the primary treating physician's progress report on July 1, 2015, the injured worker continues to experience neck pain with burning and stiffness in the lower neck and trapezius area. She also reports mid and lower back pain. The injured worker rates her pain level at 6-7 out of 10 on the pain scale without medications and 2-3 out of 10 with medications. Examination of the cervical spine demonstrated trigger points over the bilateral C5-6 paraspinals and bilateral trapezii muscles. Range of motion was reduced in all planes with pain on movement. Spurling's sign was positive bilaterally. There was no clonus, no increased tone and Hoffman's sign was negative bilaterally. Motor strength, deep tendon reflexes and sensation were intact in the bilateral upper extremities. The injured worker is requesting a trigger point injections. Six trigger point injections were administered to the cervical and trapezius area at the office visit. Current medications are listed as Duloxetine, Tizanidine, Naproxen, Voltaren gel, Plaquenil and Omeprazole. Treatment plan consists of ice then heat for injection soreness, stretching exercises and the current request for Anaprox and Prilosec.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67, 68, 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 Anaprox. NSAID should be used for the shortest duration and the lowest dose. There is no documentation from the patient's file that the provider titrated Anaprox to the lowest effective dose and used it for the shortest period possible. Anaprox 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 Anaprox 550mg #60 is not medically necessary.

Prilosec 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

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 risk for gastrointestinal events are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or

perforation; (3) concurrent use of 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. There is no documentation that the patient have GI issue that requires the use of prilosec. There is no documentation in the patient's chart supporting that she is at intermediate or high risk for developing gastrointestinal events. In fact, the patient reported GI upset with Naproxen; however, since the request for Naproxen is not certified, ongoing use of Prilosec is not necessary. Therefore, Prilosec 20mg #60 prescription is not medically necessary.