

Case Number:	CM15-0149129		
Date Assigned:	08/12/2015	Date of Injury:	03/29/2011
Decision Date:	09/09/2015	UR Denial Date:	07/20/2015
Priority:	Standard	Application Received:	07/31/2015

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: California

Certification(s)/Specialty: Family Practice

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 female, who sustained an industrial injury on 3-29-11. The injured worker was diagnosed as having carpal tunnel syndrome, rotator cuff syndrome of the shoulder, and cervicgia. Treatment to date has included right carpal tunnel release and medication. The injured worker had been taking Omeprazole, Flexeril, and Anaprox since at least 1-30-15. On 5-22-15 and 6-19-15, pain was rated as 7 of 10 without medication and 3 of 10 with medication. Currently, the injured worker complains of right shoulder and hand pain associated with mild numbness and tingling. Pain radiated to the right arm. The treating physician requested authorization for retrospective Omeprazole 20mg #60, Flexeril 7.5mg #60, and Anaprox 550mg #60 all for the date of service 6-19-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Omeprazole 20mg #60 capsules (6/19/15): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), chapter: pain (chronic), NSAIDs, GI symptoms and cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of proton pump inhibitors (PPIs), including Omeprazole, in patients who are prescribed an NSAID. Typically, PPIs are used to address gastrointestinal (GI) symptoms that may be associated with NSAID use. The MTUS guidelines state the following: Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (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). Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.); a PPI is not necessary. Patients at intermediate risk for gastrointestinal events and no cardiovascular disease : (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or misoprostol (200 ug four times daily) or (2) a Cox-2 selective agent. Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. In this case, the records indicate that the patient is at low risk for a significant GI event. The patient's age does not meet the above cited risk criteria. There is no documented history of GI bleed or ulcer. There is no evidence that the patient is on anticoagulation therapy. The patient is not taking high-dose, combination NSAID therapy. For these reasons, Omeprazole is not medically necessary.

Retrospective Flexeril 7.5mg #60 tablets (6/19/15): Upheld

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

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

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of Cyclobenzaprine/Flexeril, as a treatment modality. Flexeril is recommended as an option, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. In this case, Flexeril is being used as a long-term treatment strategy for this patient's symptoms. Long-term use is not recommended as noted in the above-cited guidelines. For this reason, Flexeril is not medically necessary.

Retrospective Anaprox 550mg #60 tablets (6/19/15): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain chapter, NSAIDs, GI symptoms, cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs
Page(s): 67-68.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of NSAIDs, including Anaprox, as a treatment modality. In general, these guidelines indicate that NSAIDs are used for acute exacerbations of chronic pain. The specific recommendations are as follows: Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. 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 than acetaminophen for acute LBP. 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. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. 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. In this case, the records indicate that Anaprox is being used as a long-term treatment strategy for this patient's symptoms. As noted in the above-cited MTUS guidelines, long-term use is not recommended. For this reason, Anaprox is not medically necessary.