MAXIMUS Federal Services

Case Number:	CM15-0163371		
Date Assigned:	08/31/2015	Date of Injury:	04/07/2014
Decision Date:	10/13/2015	UR Denial Date:	08/06/2015
Priority:	Standard	Application Received:	08/20/2015

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: California
Certification(s)/Specialty: Emergency 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 37 year old male who sustained an industrial injury on 04-07-2014 when he fell through a collapsing roof approximately 10-14 feet landing on his back and left side of his face with momentary loss of consciousness. Initial reports demonstrated a possible L4 pars fracture or congenital defect and post-concussion syndrome. Further testing revealed mild disc desiccation at L4-5 with mild broad based disc bulge. Current diagnoses are lumbago, lumbar facet syndrome, bilateral shoulder strain, left wrist strain, temporomandibular Joint (TMJ) trauma, and post-traumatic stress disorder. No surgical interventions were documented. Treatment to date has included multiple diagnostic testing, multiple specialist consultations, psychiatric and psychological evaluation with psychotherapy, dental consultation and follow-up, steroid injections, physical therapy and medications. According to the primary treating physician's progress report on July 29, 2015, the injured worker continues to experience diffuse left sided neck pain, left shoulder, jaw and lower back pain. The injured worker reported his jaw pain at 4 out of 10 exacerbated by chewing and back pain at 8 out of 10 on the pain scale. The injured worker also reports sleep difficulty, headaches, right little finger pain and depression. Examination demonstrated straightening of the cervical spine with loss of normal lordosis. Spurling's maneuver produced no pain in the neck musculature or radicular symptoms in the arm. Lumbar facet loading was positive bilaterally. The injured worker ambulates with a normal gait without assistive devices. The left shoulder demonstrated restricted range of motion due to pain with abduction at 95 degrees, passive elevation to 110 degrees, active elevation to 120 degrees, internal rotation behind the body at 80 degrees and external rotation at 85 degrees. Empty cans

test, lift-off and drop arm test were positive. Tenderness in the suprascapular area with positive Tinel's over the left suprascapular nerve was documented. There was positive dystonia of the left masseter muscle documented. Current medications were listed as Tramadol, Naproxen and Ranitidine. Treatment plan consists of continuing medication regimen, Botox injections for temporomandibular joint disorder (TMJ), left shoulder magnetic resonance imaging (MRI), bilateral L4 and L5 medial branch block and the current request for Tramadol, Naproxen and Ranitidine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 500mg #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic)/NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The request is for the use of a medication in the NSAID class. The ODG state the following regarding this topic: Specific recommendations: 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. (Chen, 2008) (Laine, 2008) Back Pain-Acute low back pain & acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting to negative evidence that NSAIDs are more effective than acetaminophen for acute LBP. (van Tulder, 2006) (Hancock, 2007) For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. (Roelofs-Cochrane, 2008) The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. (Hancock, 2007) 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. (Roelofs-Cochrane, 2008) See also Anti-inflammatory medications. 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 pain and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in patients with neuropathic pain. (Namaka, 2004) (Gore, 2006) See NSAIDs, GI symptoms & cardiovascular risk; NSAIDs, hypertension and renal function; & Medications for acute pain (analgesics). Besides the above well-documented side effects of NSAIDs, there are other less well-known effects of NSAIDs, and the use of NSAIDs has been shown to possibly delay and hamper healing in all the soft tissues, including muscles, ligaments, tendons, and cartilage. (Maroon, 2006) The risks of NSAIDs in older patients, which include increased cardiovascular risk and gastrointestinal toxicity, may outweigh the benefits of these medications. (AGS, 2009) As stated above, acetaminophen would be considered first-line treatment for chronic pain. In this case, the use of an NSAID is not advised. This is secondary to the duration of use and significant side effect profile. Also, the use of NSAIDs is known to delay the healing of soft tissue including ligaments, tendons, and cartilage. As such, the request is not medically necessary.

Ranitidine 300mg #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic)/ NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The request is for an antacid medication to aid in gastrointestinal symptoms likely related to the use of NSAIDs. The Official Disability Guidelines state the following regarding this topic: Recommend with precautions as indicated below. 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). A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. (Garcia Rodriguez, 1994) (Malfertheiner, 2009) Recommendations Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.) 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 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). 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. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007) Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. A recent systematic review concluded that slow-release formulations of NSAIDs are associated with a greater risk of upper GI bleeding/perforation, and should be used with care. The RR of upper GI bleeding/perforation was 4.50 for traditional NSAIDs, 2.69 for ibuprofen, and 1.88 for coxibs. Estimated RRs were 5.63 for naproxen immediate release, but as much as 14.54 for some slow-release formulations. In this case, the use of an antacid is indicated based on the guidelines if NSAIDs are to be continued. This is secondary to dyspepsia related to NSAID use. Unfortunately, the quantity requested is no appropriate and needs to be adjusted. As such, the request is not medically necessary.

Tramadol Hcl 50mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Product information, Ortho-McNeil 2003 (Lexi-Comp, 2008).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: Tramadol is a pain medication in the category of a centrally acting analgesic. They exhibit opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Centrally acting drugs are reported to be effective in managing neuropathic type pain although it is not recommended as first line therapy. The side effect profile is similar to opioids. For chronic back pain, it appears to be efficacious for short term pain relief, but long term (>16 weeks) results are limited. It also did not appear to improve function. The use of tramadol for osteoarthritis is indicated for short term use only (<3 months) with poor long-term benefit. In this case, the patient does not meet the qualifying criteria. This is secondary to the duration of use, with this medication being indicated on a short-term basis only. As such, the request is not medically necessary.

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