

Case Number:	CM15-0167698		
Date Assigned:	09/08/2015	Date of Injury:	10/25/2010
Decision Date:	10/07/2015	UR Denial Date:	07/30/2015
Priority:	Standard	Application Received:	08/26/2015

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 55 year old male, who sustained an industrial injury on October 25, 2010. He reported injury to his neck, back and knees. The injured worker was currently diagnosed as having lumbosacral degenerative disc disease, cervicgia, carpal tunnel syndrome, knee pain, cervical sprain, strain, lumbar sprain, strain, and long-term (current) use of medications. Treatment to date has included diagnostic studies, surgery and medication. On June 17, 2015, the injured worker complained of radicular pain and bilateral leg pain. He also reported neck pain and knee pain. The pain was rated as a 7 on a 1-10 pain scale. His Subsys medication was reported to help reduce pain. Sprix was noted for flare-ups, bringing his pain down by 50%. The treatment plan included medications and a follow-up visit. A request was made for Fenoprofen 400mg and Prilosec DR 20mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fenoprofen 400mg bid #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67, 68, and 72.

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 Fenoprofen. In general, these guidelines state that all NSAIDs should be used at the lowest dose for the shortest period of time; i.e., that they are intended for acute exacerbations of chronic pain. The specific recommendations for use of NSAIDs 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 naproxen 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. In this case, the records indicate that Fenoprofen 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. Further, there is insufficient evidence on the efficacy of Long-term use in this patient with regard to objective functional outcomes. Given the MTUS comments on long-term use of NSAIDs and the lack of supporting documentation on its efficacy, Fenoprofen 400mg BID #60 is not medically necessary.

Prilosec DR 20mg bid #60: Upheld

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

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

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of proton pump inhibitors (PPIs) as an adjunct to the use of NSAIDs. In general, PPIs are used to address adverse gastrointestinal (GI) side effects (e.g. ulcers and GI bleeding). The guidelines state that clinicians should weight the indications for NSAIDs against the GI side

effects and determine if the patient is at risk for gastrointestinal events. Risk factors include the following: (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. 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 ug 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 naproxen plus low-dose aspirin plus a PPI. In this case, the records do not indicate that the patient has any of the above cited GI risk factors. Further, there is no evidence that, as noted in the companion issue regarding Fenoprofen (an NSAID), that long-term use of an NSAID is warranted. In summary, there is no evidence that the patient should be taking a long-term NSAID and no evidence that the patient has risk factors that warrant the use of a PPI. Therefore, Prilosec DR 20mg BID #60 is not medically necessary.