

Case Number:	CM15-0168956		
Date Assigned:	09/09/2015	Date of Injury:	11/19/2009
Decision Date:	10/07/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	08/27/2015

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: North Carolina

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 female, who sustained an industrial injury on 11-19-09 from cumulative trauma resulting from assembly line work. Diagnoses include bilateral carpal tunnel syndrome; left shoulder tendonitis with possible labral injury; left shoulder internal derangement with impingement syndrome; left hip internal derangement with labral tear; left hip bursitis; left plantar fasciitis; cervical disc herniation with left upper extremity radiculopathy; lumbar disc herniation with bilateral lower extremity radicular symptoms; bilateral de-Quervain's tenosynovitis; medication induced gastritis. She currently complains of ongoing neck pain radiating down to her left upper extremity; left shoulder pain; bilateral wrist pain; lumbar spine and left hip pain. Her pain level with current medical regimen is 7 out of 10 and can go as high as 9 out of 10. On physical exam of the cervical spine there was tenderness to palpation bilaterally with increased muscle rigidity, numerous trigger points that are palpable and tender, decreased range of motion with muscle guarding, positive Spurling's sign on the left, decreased pinprick sensation bilaterally in the C5-6 distribution; left shoulder revealed tenderness along the shoulder joint line with decreased range of motion; tenderness along right thumb tendon, Finklestein's test bilaterally; lumbar spine exam revealed tenderness to palpation bilaterally with increased muscle rigidity, numerous trigger points that are palpable and tender, decreased range of motion and muscle guarding, decreased sensation in the L5-S1 distribution bilaterally, positive straight leg raise in the modified sitting position causing bilateral lower extremity radicular symptoms. Diagnostics included cervical MRI (4-11-15) showing a 2.6 millimeter disc herniation with bilateral neural foraminal stenosis; electrodiagnostic studies of the upper extremities (6-27-13) show C6 radiculopathy on the left as well as bilateral carpal tunnel syndrome; MRI of the left shoulder (9-27-13) showing tendinosis involving the supraspinatus, infraspinatus and subcapularis suggesting mild adhesive capsulitis; MRI of the left hip (9-27-13) showing degenerative changes. Treatments to date included intra-corticosteroid injection to the left shoulder (2-27-15 and 4-8-15) with three weeks of benefit; medications: Norco as needed (per the 7-23-15 note she does not abuse the medication and it enables her to perform light

household chores with less pain), Anaprox (alleviates neck and low back pain and prevents her from taking Norco on a regular basis), Prilosec (she does have medication induced gastritis symptoms per 2-27-15 note). On 7-23-15 her drug screen was inconsistent with prescribed medication as Norco was not detected; chiropractic treatments; physiotherapy treatments. In the progress note dated 7-23-15 the treating provider's plan of care included requests to refill Norco 10-325mg #60, Anaprox 550mg #60 and Prilosec 20mg #60. From the records reviewed the injured worker has been on the requested medications since at least 1-9-15. The original utilization review (8-5-15) non-certified the requests for Anaprox DS 550mg #60; Norco 10-325mg #60 (they did not wean as she takes as needed and it was not detected in the 7-23-15 drug screen); Prilosec 20mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 Tablets of Anaprox DS 550mg: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The California chronic pain medical treatment guidelines section on NSAID therapy states: 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) This medication is recommended for the shortest period of time and at the lowest dose possible. The shortest period of time is not defined in the California MTUS. The requested medication is within the maximum dosing guidelines per the California MTUS. Therefore, the request is medically necessary.

60 Tablets of Norco 10/325mg: Upheld

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

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

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid;

how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids; (a) If the patient has returned to work. (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004). The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is documentation of significant subjective improvement in pain such as VAS scores. There is no objective measure of improvement in function. For these reasons all the criteria set forth above of ongoing and continued used of opioids have not been met. Therefore, the request is not medically necessary.

60 Capsules of Prilosec 20mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The California chronic pain medical treatment guidelines section on NSAID therapy and proton pump inhibitors (PPI) states: 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). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastro duodenal 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 mg 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. There is no documentation provided that places this patient at intermediate or high risk that would justify the use of a PPI. There is no mention of current gastrointestinal or cardiovascular disease. For these reasons the criteria set forth above per the California MTUS for

the use of this medication has not been met. Therefore, the request is not medically necessary.