

<b>Case Number:</b>	CM15-0030191		
<b>Date Assigned:</b>	02/23/2015	<b>Date of Injury:</b>	06/21/2014
<b>Decision Date:</b>	05/04/2015	<b>UR Denial Date:</b>	01/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2015

### 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: District of Columbia, Virginia  
 Certification(s)/Specialty: Internal 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 51 year old female, who sustained an industrial injury on 6/21/14. She reported back and neck injury. The injured worker was diagnosed as having cervicgia with intermittent right upper extremity radiculopathy and lumbago with right lower extremity radiculopathy. Treatment to date has included Tylenol and Motrin. Currently, the injured worker complains of chronic neck pain with radiation to right upper extremity and low back pain with radiation to right buttock and posterior thigh. Upon physical exam, tenderness is noted in right paravertebral and trapezius musculature and diffuse tenderness is noted in lumbar spine with reduced range of motion. The treatment plan consists of authorization for Naprosyn and Prilosec and initiation of physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Naprosyn 500mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroid anti-inflammatory drugs (NSAIDS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792  
Page(s): 66-67.

**Decision rationale:** Naproxen is a non-steroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. See NSAIDs. See Anti-inflammatory medications. NSAIDs (non-steroidal anti-inflammatory drugs) 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 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. (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 and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. (Namaka, 2004) (Gore, 2006) See NSAIDs, GI symptoms & cardiovascular risk; NSAIDs, hypertension and renal function. 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) Long-term usage of this medication would not be medically indicated. The patient had developed chronic pain issues. A process would not be needed and this medication should be stopped immediately. Therefore, this request is not medically necessary.

**Prilosec 10mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroid anti-inflammatory drugs (NSAIDS).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chapter: Proton pump inhibitors.

**Decision rationale:** MTUS does not address this medication. Per ODG: Proton pump inhibitors (PPI) are recommended for patients at risk for gastrointestinal events. See NSAIDS, GI symptoms and cardiovascular risk. Prilosec (omeprazole), Prevacid (lansoprazole) and Nexium (esomeprazole) are PPIs. Omeprazole provides a statistically significantly greater acid control than lansoprazole (Miner 2010). Healing doses of PPIs are more effective than all other therapies although there is an increase in overall adverse effects to placebo. Nexium and Prilosec are very similar molecules. For many people, Prilosec is more affordable than Nexium. Nexium is not available in a generic (as in Prilosec). In addition, Prilosec is more available as an over the counter product while Nexium is not. (Donnellan 2010) In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose or the shortest possible amount of time. PPIs are more effective including preventing gastric ulcers induced by NSAIDS. Studies suggest however that nearly half of all PPI prescriptions are used for unapproved indications or no indications at all. Many prescribers believe that this class of drugs is innocuous but much information is available to demonstrate otherwise. If a PPI is used, Omeprazole OTC tablets or Lansoprazole 24 HR OTC are recommended for an equivalent clinical efficacy and significant cost savings. Products in this drug class have demonstrated equivalent clinical efficacy and safety at comparable doses, including Nexium, Prevacid, Prilosec, Protonix , Dexilant and Aciphex (Shi 2008). A trial of Omeprazole or Lansoprazole is recommended before Nexium therapy. The other PPIs, Protonix, Dexilant, Aciphex should also be second line. According to the latest AHRQ comparative effectiveness research, all of the commercially available PPIs appeared to be similarly effective (AHRQ 2011) (Pain Chapter).The patient had indications for Prilosec, but the duration would exceed that which is recommended. The patient no longer meets criteria for NSAIDs and therefore would not need a PPI. Therefore, this current regimen is not medically necessary.