

<b>Case Number:</b>	CM15-0057934		
<b>Date Assigned:</b>	04/06/2015	<b>Date of Injury:</b>	01/04/2014
<b>Decision Date:</b>	06/16/2015	<b>UR Denial Date:</b>	03/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 (IW) is a 63 year old female who sustained an industrial injury on 01/04/2014. She reported pain in the right knee. The injured worker was diagnosed as having right knee pain, question of internal derangement of the right knee, and myofascial pain syndrome. Treatment to date has included diagnostic x-rays and MRI's, non-steroidal anti-inflammatories, Neurontin, Omeprazole, and Flexaril. Currently, the injured worker complains of pain in the right knee especially with longer periods of walking and standing. She also has muscle spasms in the right knee and paresthesias in the right knee and foot. She experiences dizziness and vertigo. Ibuprofen has relieved the pain in the past but upsets her stomach. She is willing to have acupuncture to avoid surgery on the knee and is open for pain management without narcotic usage. A request for authorization is made for Naproxen 550mg #200, Omeprazole 20mg #300, Neurontin 600mg #300, and Flexeril 7.5mg #270.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Naproxen 550mg #200:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73.

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

**Decision rationale:** Per the MTUS, NSAIDs are 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. A review of the injured workers medical records that are available to me reveal subjective and objective documentation of the injured workers pain and the continued use of an NSAID would be appropriate in the injured worker, the medication appears to have been dispensed in bottles of 100 totaling 200, the injured worker is being prescribed 3 months worth for twice a day dosing, therefore the request for Naproxen 550mg #200 is medically necessary.

**Omeprazole 20mg #300:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) / Proton Pump Inhibitors (PPIs).

**Decision rationale:** Per the MTUS, Clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors according to specific criteria listed in the MTUS and a selection should be made based on these criteria 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). Per the ODG, PPI's are Recommended for patients at risk for gastrointestinal events. Prilosec (omeprazole), Prevacid (lansoprazole) and Nexium (esomeprazole magnesium) are PPIs. Healing doses of PPIs are more effective than all other therapies, although there is an increase in overall adverse effects compared to placebo. Nexium and Prilosec are very similar molecules. (Donnellan, 2010) In this RCT omeprazole provided a statistically significantly greater acid control than lansoprazole. (Miner, 2010) In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. PPIs are highly effective for their approved indications, 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. Products in this drug class have demonstrated equivalent clinical efficacy and safety at comparable doses, including esomeprazole (Nexium), lansoprazole (Prevacid), omeprazole (Prilosec), pantoprazole (Protonix), dexlansoprazole (Dexilant), and rabeprazole (Aciphex). (Shi, 2008) A trial of omeprazole or lansoprazole had been recommended before prescription Nexium therapy (before it went OTC). The other PPIs, Protonix, Dexilant, and Aciphex, should be second-line. According to the latest AHRQ Comparative Effectiveness Research, all of the commercially available PPIs appeared to be similarly effective. (AHRQ, 2011). A review of the injured workers medical records that are available to me reveal complaints of gastric irritation with the use of NSAIDs and the use of omeprazole is appropriate in the injured worker, she was prescribed omeprazole 20mg once a day and 3 months worth was dispensed in 3 bottles of 100, the injured worker really only needs 90 for 3 months and the rationale for requesting 300 is not clear from the medical records therefore he request for Omeprazole 20mg #300 is not medically necessary.

**Neurontin 600mg #300:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-20.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AED's) Page(s): 16-22.

**Decision rationale:** Per the MTUS, antiepilepsy drugs are recommended for neuropathic pain. Gabapentin is considered first line treatment for neuropathic pain. The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions. A good response to the use of AEDs has been defined as a 50% reduction in pain and a moderate response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the trigger for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails.(Eisenberg, 2007) (Jensen, 2006) After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Unfortunately a review of the injured workers medical records did not yield documentation of the injured workers response to gabapentin per guideline recommendations as described above and without this information medical necessity for continued use is not established.

**Flexeril 7.5mg #270:** 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): 41-42.

**Decision rationale:** Per the MTUS, Cyclobenzaprine is recommended as an option in the treatment of chronic pain using a short course of therapy. It 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. A review of the injured workers medical records reveal that the request is for 3 months worth of Flexeril, and while it is noted that the injured worker has spasms in her right knee, there is no documentation of improvement in pain or function with the use of Flexeril as required by the guidelines and therefore the continued use of Flexeril is not medically necessary.