

Case Number:	CM15-0062650		
Date Assigned:	04/08/2015	Date of Injury:	11/16/2007
Decision Date:	05/07/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	04/02/2015

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 50 year old male, who sustained an industrial injury on 11/16/2007. He has reported injury to the neck and left shoulder. The diagnoses have included cervical radiculopathy; left shoulder bursitis; and status post left shoulder arthroscopy. Treatment to date has included medications, diagnostics, acupuncture, and surgical intervention. Medications have included Naproxen Sodium, Tramadol ER, Cyclobenzaprine, and Pantoprazole. A progress note from the treating physician, dated 02/10/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of cervical pain with left greater than right upper extremity symptoms, rated 6/10 on the visual analog scale; left shoulder pain, rated at 5/10; and acupuncture has been helpful. Objective findings included diffuse tenderness of the cervical spine with decreased range of motion; spasm of the cervical trapezius and cervical paraspinal musculature; and tenderness of the left shoulder with decreased ranged of motion and positive bursitis. The treatment plan has included additional acupuncture sessions to the cervical spine; and prescription medications. Request is being made for Retrospective Naproxen Sodium 550 mg #90; Retrospective Pantoprazole 20 mg #90; and for Retrospective Cyclobenzaprine 7.5 mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Naproxen sodium 550mg #90 (DOS 02/10/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen, NSAIDs (non-steroidal anti-inflammatory drugs).

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, such as Naproxen, as a treatment modality. Their specific recommendations 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 naproxyn 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. 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. 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. 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 Naproxen is being used as a long-term treatment strategy for this patient's pain. Long-term use is not recommended per the above cited guidelines. There is insufficient documentation in support of the long-term use of Naproxen. For these reasons, Naproxen is not considered as medically necessary.

Retrospective Pantoprazole 20mg #90 (DOS 02/10/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

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

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of Proton Pump Inhibitors (PPI), such as Pantoprazole, as an adjunct to the use of an NSAID. Regarding the use of a PPI, the MTUS guidelines state the following: Clinicians should 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 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 (200g 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. In this case, the records do not indicate that this patient is at risk for a gastrointestinal event. The patient does not meet the above cited criteria for the need to add a PPI to his treatment regimen. For this reason, the use of Pantoprazole is not considered as medically necessary.

Retrospective Cyclobenzaprine 7.5mg #90 (DOS 02/10/15): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of cyclobenzaprine as a treatment modality. Cyclobenzaprine is recommended as an option, using a short course of therapy. Cyclobenzaprine (Flexeril) 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. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. In this case, the records indicate that cyclobenzaprine is being used as a long-term treatment strategy for this patient's pain syndrome. Long-term use of cyclobenzaprine is not recommended per the above cited MTUS guidelines. There is insufficient documentation in support of the need for long-term use. For these reasons, cyclobenzaprine is not considered as medically necessary.