

Case Number:	CM14-0211532		
Date Assigned:	12/24/2014	Date of Injury:	05/19/2009
Decision Date:	02/19/2015	UR Denial Date:	12/06/2014
Priority:	Standard	Application Received:	12/17/2014

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:

This 53-year-old carpet cleaner reported a right knee injury after his knee buckled and he fell as he was carrying a 100-lb buffer down steps on 5/19/09. He subsequently reported a compensatory left knee injury, bilateral Achilles tendonitis, neck and low back injuries, anxiety and depression. MRI of the right knee done in 7/2009 revealed tricompartmental osteoarthritis, severe in the medial joint compartment, with avascular necrosis, a torn medial meniscus and a chronic ACL tear. An MRI of the left knee performed in 2/2011 revealed tricompartmental osteoarthritis, medial and lateral meniscal tears, a full thickness tear of the ACL, and a Baker's cyst. He began treating with his current primary provider, an orthopedist, on 10/29/10. Initial treatment included a compression garment, tramadol, naproxen and physical therapy. He received several viscosupplementation injections, but has apparently been unwilling to undergo surgery. The two most recent notes from the primary treater's office are dated 8/5/14 and 11/11/14. Both note that the patient continues to have multifocal pain. Limited range of motion of his neck, back and both lower extremities is documented on 8/5/14, and tenderness of the neck, back and both knees with an antalgic wide-based gait is noted on 11/11/14. Diagnoses include internal derangement of both knees, discogenic lumbar condition "with radicular component down the lower extremities", discogenic cervical condition "with radicular component down the upper extremities", chronic pain, anxiety, depression, sleep disorder, sexual dysfunction, and headaches. Medications dispensed at both visits included naproxen 550 mg #60. The stated rationale for the naproxen is that it is "for anti-inflammation" on 8/5/14 and "for inflammation" on 11/11/14. He is documented as having no hypertension at both visits.

However, a blood pressure of 157/89 is recorded at the 8/5/14 visit. There is no recorded blood pressure on 11/11/14. The patient has not worked since 2009. The request for Naproxen 550 mg was non-certified in UR on 12/6/14. MTUS Chronic Pain Guidelines were cited as the basis for the non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen Sodium Tablets 550 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91-92, 68-71.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; NSAIDs (non-steroidal anti-inflammatory drugs); NSAIDs; Hypertensi.

Decision rationale: Naproxen Sodium is a non-steroidal anti-inflammatory drug (NSAID). Per the first reference cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. The NSAID references state that NSAIDs are recommended at the lowest dose for the shortest period possible for patients with moderate to severe pain due to osteoarthritis. There is no evidence to recommend one drug over another in terms of efficacy or pain relief. Cardiovascular risk occurs with all NSAIDs, and there is no evidence of long-term effectiveness for pain or function. NSAIDs are recommended as an option for short-term symptomatic relief of chronic low back pain. There is inconsistent evidence to support their use for neuropathic pain. All NSAIDs have the potential to raise blood pressure in susceptible patients. The greatest risk appears to occur in patients taking ACE inhibitors, ARBs, beta-blockers or diuretics. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. The medical findings in this case do not support the use of naproxen sodium 550 mg. This patient has been taking naproxen for years. It is not clear whether it is being used for knee osteoarthritis, for low back pain, or for radicular pain, but there is no good evidence supporting long-term use of naproxen for any of these conditions. There is no documentation of any improvement in function while he has been taking it, and he remains totally disabled. There is no documentation of any flare of the patient's chronic pain which would require NSAID use. There is no documentation of the patient's cardiovascular or GI risk factors. It does appear likely that he has hypertension, and may be at risk for cardiovascular events. According to the evidence-based citations above and to the clinical documentation provided for my review, naproxen sodium 550 #60 is not medically indicated for this patient. It is not medically necessary because it is not likely to be helpful for treatment of long-term knee osteoarthritis, for long-term low back pain, or for neuropathic pain; because the patient's level of function has not improved while taking it, because there is no documentation of an assessment for GI or cardiovascular risk factors, and because it appears possible to likely that it is placing this patient at increased risk for a cardiac event.