

Case Number:	CM15-0001797		
Date Assigned:	01/12/2015	Date of Injury:	07/14/2012
Decision Date:	03/09/2015	UR Denial Date:	12/06/2014
Priority:	Standard	Application Received:	01/05/2015

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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:

This 42 year old female was injured 7/14/12. The mechanism of injury was not clear but utilization review indicated a fall. Current complaints include neck pain with radiation to bilateral upper extremities with numbness 3-4/10 decreasing to 0/10 with medications; bilateral shoulder pain, 9/10 decreasing to 8/10 with medications; bilateral wrist and hand pain 9/10 decreasing to 7-8/10 with medications; low back pain with radiation to bilateral lower extremities with numbness, 9/10 decreasing to _/10 with medications; bilateral knee pain, 9/10 decreasing to 6/10 with medications. Medications include Terocin, flurbi (NAP) cream, gabapentin, Anaprox, Prilosec and cyclobenzaprine. Diagnoses were cervical disc bulge, radiculopathy, sprain/strain; shoulder internal derangement, sprain/strain; rotator cuff syndrome; carpal tunnel syndrome; hand sprain/ strain/ triggering; lumbar disc bulge, radiculopathy, sprain/strain; knee internal derangement. Diagnostic studies included MRI of the cervical and lumbar spine, bilateral hand and wrist, bilateral shoulders (2013) and electromyography of the upper extremities (undated). Treatments included bilateral wrist brace and to continue with medications. The treating provider requested naproxyn, omeprazole and cyclobenzaprine as they do help to alleviate the injured workers pain. On 12/6/14 Utilization Review (UR) non-certified the request for naproxyn 550mg X 60 for lumbar and bilateral knee pain based on lack of documentation regarding first line therapy. Without documentation of tried and failed first-line therapy the request is not supported by evidence based guidelines. Omeprazole 20 mg X 60 was non-certified based on lack of documentation regarding if the injured worker was at increased risk for gastrointestinal events or has complaints of dyspepsia secondary to non-steroidal anti-

inflammatory use. Cyclobenzaprine 10 mg X 60 was non-certified based on guidelines discouraging use longer than 2-3 weeks. Guidelines referenced were MTUS.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen Sodium DS Tablets 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NON SELECTIVE NSAIDS Page(s): 72.

Decision rationale: Naproxen (Naprosyn): delayed release (EC-Naprosyn), as Sodium salt (Anaprox, Anaprox DS, Aleve [otc]) Generic available; extended-release (Naprelan): 375 mg. Different dose strengths and formulations of the drug are not necessarily bioequivalent. Dosing Information: Osteoarthritis or ankylosing spondylitis: Dividing the daily dose into 3 doses versus 2 doses for immediate-release and delayed-release formulations generally does not affect response. Morning and evening doses do not have to be equal in size. The dose may be increased to 1500 mg/day of naproxyn for limited periods when a higher level of analgesic/anti-inflammatory activity is required (for up to 6 months). Naprosyn or naproxyn: 250-500 mg PO twice daily. Anaprox: 275-550 mg PO twice daily. (total dose may be increased to 1650 mg a day for limited periods). EC-Naprosyn: 375 mg or 500 mg twice daily. The tablet should not be broken, crushed or chewed to maintain integrity of the enteric coating. Naprelan: Two 375 mg tablets (750 mg) PO once daily or two 500 mg tablets (1000 mg) once daily. If required (and a lower dose was tolerated) Naprelan can be increased to 1500 mg once daily for limited periods (when higher analgesia is required). Pain: Naprosyn or naproxyn: 250-500 mg PO twice daily. The maximum dose on day one should not exceed 1250 mg and 1000 mg on subsequent days. Anaprox: 275-550 mg PO twice daily. The maximum dose on day one should not exceed 1375 mg and 1100 mg on subsequent days. Extended-release Naprelan: Not recommended due to delay in absorption. (Naprelan Package Insert) There is no documentation of the rationale behind the long-term use of Naproxen. NSAID should be used for the shortest duration and the lowest dose. There is no documentation from the patient file that the provider titrated Naproxen to the lowest effective dose and used it for the shortest period possible. Naproxen was used without clear documentation of its efficacy. Furthermore, there is no documentation that the provider followed the patient for NSAID adverse reactions that are not limited to GI side effect, but also may affect the renal function.

Cyclobenzaprine 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: According to MTUS guidelines, Cyclobenzaprine a non sedating muscle relaxants is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic spasm and pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The guidelines do not recommend to be used for more than 2-3 weeks. The patient in this case does not have clear significant functional improvement with prior use of muscle relaxants. There is no indication of recent evidence of spasm.

Omeprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: According to MTUS guidelines, Omeprazole is indicated when NSAID are used in patients with intermediate or high risk for gastrointestinal events. The risk for gastrointestinal events are: (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. There is no documentation in the patient's chart supporting that she is at intermediate or high risk for developing gastrointestinal events.