

Case Number:	CM15-0011674		
Date Assigned:	01/29/2015	Date of Injury:	04/16/2005
Decision Date:	03/18/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	01/20/2015

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: Ohio, North Carolina, Virginia
 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 49 year old female, who sustained an industrial injury dating 04/16/2004-04/16/2005; 11/2002-11/2003. The diagnoses have included cervical post laminectomy syndrome with left C7 radiculopathy, status post Prodisc replacement C4-5 and C5-6, and status post ACDF (anterior cervical discectomy and fusion). Treatments to date have included acupuncture, cognitive behavior therapy, and medications. Diagnostics to date have included electromyography on 03/04/2014 showed left chronic C7 radiculopathy and CT Scan on 12/14/2006 showed postoperative changes including metallic interbody fusion device at C4-5 and C5-6. In a progress note dated 12/19/2014, the injured worker presented with complaints of neck pain with associated cervicogenic headaches as well as radicular symptoms to her left upper extremity. The treating physician reported the injured worker continues to require strong medications due to the debilitating neuropathic pain in her neck. Utilization Review determination on 01/08/2015 non-certified the request for Anaprox DS 550 x 60 and Prilosec 20mg x 60 citing Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox Ds 55 #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: NSAIDS like Anaprox DS 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 naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. In this instance, the combination of medication taken by the injured worker reduces her pain from 8/10 to a 6/10. The pain management options for this injured worker are limited by a recent suicide attempt that involved opioid medication. A strict interpretation of the guidelines does not require that there be documented functional improvement with NSAID use. Merely, they should be used at the lowest possible doses for the shortest period of time possible. This essentially amounts to a judgement call by the treating physician. Therefore, Anaprox DS 550 mg #60 is medically necessary.

Prilosec 20mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms, and cardiovascular risk Page(s): 68-69.

Decision rationale: Clinicians should weight the indications for NSAIDS against both GI and cardiovascular risk factors. 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 (200 ?g 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. Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. In this instance, the injured worker has a documented history of gastritis. Anaprox DS 550 mg twice daily is also considered high dose NSAID therapy. Therefore, there are 2 reasons for proton pump inhibitor use in this instance. Hence, Prilosec 20mg #60 is medically necessary.