

Case Number:	CM15-0013932		
Date Assigned:	02/02/2015	Date of Injury:	12/30/2010
Decision Date:	03/25/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	01/23/2015

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:

The injured worker is a 45 year old male, who sustained an industrial injury on 12/30/2010. The diagnoses have included other specified disorders of bursae and tendons in shoulder region and other affections of shoulder region, not elsewhere classified. Treatment to date has included surgical interventions, noting right carpal tunnel release and right elbow lateral epicondylar release in 2013, and conservative measures. Currently, the injured worker complains of ongoing pain in the right shoulder, rated 7/10, right elbow pain, rated 6/10, and right hand/wrist pain, rated 5/10. Examination of the right wrist/hand showed extension 60degrees, flexion 60 degrees, radial deviation 20 degrees, and ulnar deviation 30 degrees. Examination of the right shoulder demonstrated flexion 140 degrees, abduction 130 degrees, external rotation 50 degrees, and abduction and extension 40 degrees. Also noted were positive subacromial bursitis and O'Brien's test. Tramadol ER at 300mg/day was noted for pain decrease of 4-5 points on a scale of 10. Hydrocodone 10mg was utilized for breakthrough pain. Non-steroidal anti-inflammatory medications were noted for 2-3 point decrease in pain component. Proton pump inhibitor medication was used for gastrointestinal protection with medication use. Cyclobenzaprine was used for decrease in spasm. On 1/14/2015, Utilization Review (UR) non-certified a prescription request for Naproxen 550mg #90, citing the MTUS Chronic Pain Medical Treatment Guidelines. The UR non-certified a prescription request for Pantoprazole 20mg #90, citing the Official Disability Guidelines. The UR modified a prescription request for Cyclobenzaprine 7.5mg #90, to Cyclobenzaprine 7.5mg #20, citing the MTUS Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen DOS 550mg, #90: Upheld

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

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. Therefore, the request for Naproxen Sodium 550mg #90 is not medically necessary.

Pantoprazole DOS 20mg, #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Proton Pump Inhibitors (PPIs)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 102.

Decision rationale: According to MTUS guidelines, Protonix 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 that the patient is at an increased risk of GI bleeding. Therefore the prescription of Pantoprazole 20mg, # 90 is not medically necessary.

Cyclobenzaprine 7.5mg,#90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines: Muscle Relaxants

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 form more than 2-3 weeks. The patient in this case does not have clear recent evidence of spasm and the prolonged use of Cyclobenzaprine is not justified. Therefore, the request for Cyclobenzaprine 7.5mg #90 is not medically necessary.