

Case Number:	CM15-0110515		
Date Assigned:	06/17/2015	Date of Injury:	09/03/2003
Decision Date:	07/15/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	06/08/2015

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, Alabama, 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 is a 72 year old female with a September 3, 2003 date of injury. A progress note dated May 13, 2015 documents subjective findings (quite a bit of pain in the left knee, especially at night; intermittent pain in the right wrist and the thumb), objective findings (tenderness along both knees especially at the lateral aspect of the left knee; some swelling across the joint line on the left and negative on the right; decreased range of motion of the knees; tenderness across the joint line more laterally than medially; positive McMurray's laterally on the left knee), and current diagnoses (internal derangement of the knee bilaterally; depression, sleep, stress and weight loss due to chronic pain; issues with the base of the thumb on the right side that flares up from time to time). Treatments to date have included bilateral total knee arthroplasty, medications, use of a cane, and a transcutaneous electrical nerve stimulator unit. The medical record identifies that medications help control the pain, and that the injured worker should undergo x-rays of the knees to evaluate for remaining articular surface. The treating physician documented a plan of care that included x-rays of the bilateral knees, Protonix, and Naproxen.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-ray anterior posterior -standing x-ray of the bilateral knees: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

Decision rationale: According to MTUS guidelines, X ray of the knee is recommended in case of patello femoral syndrome. There is no documentation of knee patella-femoral dysfunction in this case. Therefore, the request for X-ray anterior posterior -standing x-ray of the bilateral knees is not medically necessary.

Protonix 20mg quantity 60: Upheld

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

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 Protonix 20mg #60 is not medically necessary.

Naproxen 550mg quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs.

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 using 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. 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. There is no documentation that the patient developed arthritis pain that justify continuous use of Naproxen. There is no documentation of pain and functional improvement with the previous use of Naproxen. Therefore, the request for Naproxen 550mg #60 is not medically necessary.