

Case Number:	CM15-0111835		
Date Assigned:	06/18/2015	Date of Injury:	10/15/2011
Decision Date:	07/16/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/09/2015

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: North Carolina

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 63 year old male, who sustained an industrial injury on October 15, 2011. He reported a left knee and left shoulder injury. The injured worker was diagnosed as having cervical musculoligamentous injury, left shoulder internal derangement, lumbar musculoligamentous injury with bilateral lower extremities radicular symptoms, left knee internal derangement status post left total knee replacement in August 2014, right knee internal derangement status post right total knee replacement on April 13, 2015, and medication induced gastritis. Diagnostic studies to date have included MRIs, x-rays, and urine drug screening. On July 3, 2014, an MRI of the lumbar spine revealed disc protrusions at lumbar 5-sacral 1 with facet arthropathy and bilateral neural foraminal stenosis. On July 3, 2014, an MR arthrogram of the left shoulder grade 1 tendinosis at the musculoligamentous junction of the supraspinatus and infraspinatus tendon without a tear. Treatment to date has included physical therapy, a lower back trigger point injection with 50% relief in November 2014, left shoulder steroid injections with relief, a home exercise program, a transcutaneous electrical nerve stimulation (TENS) unit was ineffective, and medications including opioid, muscle relaxant, proton pump inhibitor, benzodiazepine, and non-steroidal anti-inflammatory. On May 8, 2015, the injured worker complains of right knee pain. He is status post a right total knee replacement on April 15, 2015. He uses a rolling walker for ambulation. He complains of lower back pain radiating down to the bilateral lower extremities. His back pain is rated 8/10. He complains of continued left shoulder pain. His current medications include two short-acting opioids, proton pump inhibitor, non-steroidal anti-inflammatory, and a benzodiazepine. The treating physician noted the injured worker's inability to tolerate Anaprox as it causes significant headaches. To help him sleep at night he uses Doral. He has significant pain and muscle spasm to the lower back, bilateral knees, and left shoulder without his current medications. A urine drug screen was performed and was positive for opiates, which is consistent. The injured worker underwent 4 lumbar trigger point

injections with greater than 50% pain relief and increased range of motion after a few minutes. The treatment plan includes starting a long-acting opioid and continuing his current medications. Requested treatments include: Anaprox DS, Prilosec, and Doral.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox DS 550mg BID PRN #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 68-72.

Decision rationale: The California chronic pain medical treatment guidelines section on NSAID therapy states: 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. (Chen, 2008) (Laine, 2008) This medication is recommended for the shortest period of time and at the lowest dose possible. The shortest period of time is not defined in the California MTUS. The requested medication is not within the monthly maximum dosing guidelines per the California MTUS. Therefore the request is not certified.

Prilosec 20mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 68-72.

Decision rationale: The California chronic pain medical treatment guidelines section on NSAID therapy and proton pump inhibitors (PPI) states: Recommend with precautions as indicated below. 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 gastro duodenal 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 mg 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. There is no documentation provided that places this patient at intermediate or high risk that would justify the use of a PPI. There is no mention of current gastrointestinal or cardiovascular disease. For these reasons the criteria set forth above per the California MTUS for the use of this medication has not been met. Therefore, the request is not certified.

Doral 15mg 1 PO QHS #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines Page(s): 22.

Decision rationale: The California chronic pain medical treatment guidelines section on benzodiazepines states: Benzodiazepines Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005) The chronic long-term use of this class of medication is recommended in very few conditions per the California MTUS. There is no evidence however of failure of first line agent for the treatment of anxiety in the provided documentation. For this reason, the request is not certified.