

<b>Case Number:</b>	CM15-0114067		
<b>Date Assigned:</b>	06/25/2015	<b>Date of Injury:</b>	06/20/2008
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	05/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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 58 year old female who sustained an industrial injury on 6/20/08. Diagnoses are lumbar radiculopathy, cervical radiculopathy, and chronic pain syndrome. In a report of initial evaluation and request for treatment dated 4/20/15, the physician notes complaints of pain to her neck radiating to the left upper extremity. Pain is described as constant, throbbing, and aching and rated at 8-9 out of 10. Pain decreases with medications and rest. She complains of low back pain radiating down the left lower extremity with numbness and tingling to the left leg. Pain is described as constant, sharp, throbbing, aching and rated at 9 out of 10. Pain decreases with medications and rest. She is not working at this time. She walks with a normal gait. Exam of the cervical spine reveals tenderness to palpation over the bilateral scalene, trapezius, levator scapulae, rhomboid muscles and bilateral C3-4, C5, C6 and C7 spinous processes. Range of motion is in degrees as follows; flexion to 50, extension to 40, right rotation to 40, left rotation to 30, right lateral bending to 70 and left lateral bending to 60. Sensory response is decreased in the left C5 and C6 dermatomes. Exam of the lumbar spine reveals tenderness to palpation, range of motion is limited, straight leg raising is positive on the left at 60 degrees and on the right at 70 degrees. Sensory response is decreased in the left L4, L5, and S1 dermatomes. Previous treatment noted includes x-rays, MRI-11/11/11, medications, 3 lumbar epidural steroid injections-with no benefit, chiropractics, electromyogram/nerve conduction studies-4/12/12, and physical therapy. The treatment plan is to manage her pain with oral analgesics; start Gabapentin and Norco, renew Naproxen and Omeprazole, and discontinue Carisoprodol. The treatment requested is Naproxen 500 mg #60 and Omeprazole 20 mg #60.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Naproxen 500mg #60: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen; NSAIDs (non-steroidal anti-inflammatory drugs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**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 naproxen 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 within the maximum dosing guidelines per the California MTUS. Therefore, the request is medically necessary.

### **Omeprazole 20mg #60: Upheld**

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

**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 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. 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 medically necessary.