

Case Number:	CM15-0116853		
Date Assigned:	06/25/2015	Date of Injury:	03/21/2008
Decision Date:	08/27/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	06/17/2015

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 York

Certification(s)/Specialty: Emergency 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 50 year old male who sustained an industrial injury on 03/21/2008 as the result of cumulative trauma with noted pain/injuries to the neck, bilateral shoulders, bilateral knees, bilateral ankles, and low back. Treatment provided to date has included: physical therapy, acupuncture; right carpal tunnel release, cervical spine surgery, lumbar injection resulting in significant pain reduction in the low back and lower extremity further resulting in a reduction in medication, cortisone injection to the left shoulder; medications, and conservative therapies. Diagnostic tests performed include: MRI of the cervical spine showing a 3.5mm disc protrusion at C5-6, MRI of the lumbar spine showing a disc herniation at L4-5 with neuroforaminal narrowing and central disc herniation at L5-S1 with bilateral neuroforaminal stenosis. Additional testing included an MRI of both knees showing internal derangement with osteoarthritic changes bilaterally, right shoulder MRI showing a partial rotator cuff tear; MRI of both ankles showing partial tearing of the flexor hallucis longus bilaterally; and electrodiagnostic, and nerve conduction testing revealing mild to moderate chronic C5 and C6 radiculopathy with bilateral carpal tunnel syndrome. Other noted dates of injury documented in the medical record include 2006 and 2007. Comorbidities included coronary artery disease with a previous myocardial infarction in 2006 and without recurrent chest pain, history of seizure disorder possibly due to medication, and abdominal pain like due to medications. On 05/20/2015, physician progress report noted complaints of severe bilateral neck pain with associated bilateral upper extremity pain, numbness and weakness. Additional complaints included severe bilateral leg pain, numbness and weakness (left greater than right), chronic severe headaches, intermittent

abdominal pain, left knee pain with instability, depression and anxiety. The injured worker reported that his overall pain severity rating was 8/10. Current medications include OxyContin 60mg twice daily, hydrocodone/acetaminophen 10/325mg 4 times daily, Anaprox 550mg twice daily (first prescribed 11/20/2014), and Fioricet twice daily. The physical exam revealed a blood pressure of 160/75, restricted range of motion (ROM) in the cervical spine, tenderness to palpation in the trapezius muscles bilaterally, improved (but still restricted) ROM in the lumbar spine, minimal tenderness over the paravertebral and gluteal muscles, mildly positive straight leg raise on the left, subluxation of the left knee, decreased ROM in the left knee with swelling and tenderness, tenderness to the right knee with normal ROM, and decreased RM with tenderness in the bilateral shoulders. The injured worker underwent a lumbar epidural steroid injections on 08/28/2014 which resulted in a 50% decrease in pain for a couple of months; however, the pain began gradually increasing in 10/2014. A urine drug screening dated 09/25/2014 was noted to be inconsistent with prescribed medications. The provider noted diagnoses of cervical radiculopathy, and bilateral knee osteoarthritis. Plan of care includes continuation of current medications (including Anaprox, OxyContin, and Fioricet), knee stabilization brace, and follow-up. The injured worker's work status remained temporarily totally disabled. The request for authorization and IMR is for Anaprox 550mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications, NSAIDS (Non-Steroidal Anti-Inflammatory Drugs) Page(s): 22, 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

Decision rationale: According to the MTUS, "NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe osteoarthritic pain (including knee and hip). NSAIDs include gastrointestinal (GI) and cardiovascular side effects which are increased in patients with pre-existing cardiovascular and GI risk factors or diagnoses. There appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief; however, COX-2 NSAIDs have fewer GI side effects, but may have increased cardiovascular side effects. Although the FDA has concluded that long-term clinical trials suggest that cardiovascular risk occurs with all NSAIDs, naproxyn (Anaprox) appears to be the safest drug. It is recommended that if there is greater cardiovascular risk than GI risk the suggestion is naproxyn plus low-dose aspirin plus a proton pump inhibitor (PPI). This is the same recommendation in patient with major cardiovascular risk factors such as recent MI. NSAIDs are also recommended "with precaution" in patient with hypertension as they have the potential to raise blood pressure in susceptible patients." After reviewing the clinical documentation, it was noted that the injured worker has a diagnoses of osteoarthritis in the knees with moderate to severe pain. It was also noted that the injured worker has a history of abdominal pain with the use of medications and a history of a MI. Although there was no documented diagnosis of hypertension, it was noted that

in the exams after the Anaprox was first prescribed (11/20/2015), the injured worker's blood pressure was consistently increasing with each exam. In addition, there is no evidence of the addition of a PPI and aspirin with the Anaprox thus increasing the injured worker's risk for cardiovascular and GI side effects. Moreover, there was no documented decrease in the injured worker's levels of pain (particularly in the knees) or improvement in function since starting the Anaprox. Therefore, considering the lack of benefit from the use of Anaprox as well as the injured worker's medical history, recent increase in blood pressures and history of GI complaints, it has been determined that the Anaprox is not medically necessary.