

<b>Case Number:</b>	CM13-0012439		
<b>Date Assigned:</b>	03/28/2014	<b>Date of Injury:</b>	01/27/2011
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	07/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2013

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 43 year old male with a work injury dated 1/27/11. The diagnoses include right knee internal derangement; right shoulder impingement syndrome; sleep disturbance; umbilical hernia; and right scapula lipoma. There are requests for acupuncture 2 times per week for 4 weeks right knee and shoulder, Fluriflex cream , TGHOT cream, Naproxen, Tizanidine, Hydrocodone/APAP, and Omeprazole. There is a 6/19/13 physical exam which states that the patient complains of right shoulder and right knee pain. On examination of the right scapula, the patient's incision from the excision of the lipoma is totally closed. There is still some induration. There is no erythema. There is some tenderness. His shoulder mobility is still somewhat impaired. His neck motion is intact. With respect to the patient's right knee, there is still crepitus and limited motion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ACUPUNCTURE 2X WEEK X4 WEEKS RIGHT KNEE AND SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The MTUS Acupuncture Medical Treatment Guidelines recommend that the time to produce functional improvements is 3-6 treatments and acupuncture treatments may be extended if functional improvement is documented. The request as written would exceed the recommended number of visits and; therefore, acupuncture 2 times per week for 4 weeks right knee and shoulder is not medically necessary.

**FLURIFLEX CREAM 3180 GMS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

**Decision rationale:** The ointment Fluriflex contains Flurbiprofen 15% and Cyclobenzaprine 10%. The MTUS guidelines state that there is little evidence to support the use of topical NSAIDS (flurbiprofen is an NSAID) for the treatment of osteoarthritis of the spine, hip, or shoulder and there is no evidence to support the use of Cyclobenzaprine (a muscle relaxant). The guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Furthermore the guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Furthermore, the documentation does not indicate that patient is intolerant to oral medications. The request for Fluriflex cream is not medically necessary.

**TGHOT CREAM #180 GMS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES , NSAIDS

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

**Decision rationale:** TGHOT 180 grams is not medically necessary per the MTUS guidelines. Per the guidelines topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The documentation submitted does not indicate the ingredients contained in THGot and therefore without a description of this medication the medical necessity cannot be established. The request for THGot is not medically necessary.

**NAPROXEN 50 MG #100:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: NSAIDS

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications and Naproxen Page(s): 22 and 66.

**Decision rationale:** Naproxen Sodium 50mg #100 is not medically necessary per MTUS guidelines. Naproxen is an anti-inflammatory. Per guidelines anti-inflammatories are recommended as an option for short-term symptomatic relief. The patient has been on Naproxen since at least February of 2013. Documentation indicates that the patient has been on this medication without significant functional improvement or significant decrease in pain. Additionally the request does not indicate how often patient is to take Naproxen. Therefore, Naproxen Sodium #100 is not medically necessary.

**TIZANIDINE 4 MG #120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ANITSPASTICITY/ANTISPASMODIC DRUGS

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) and Tizanidine (Zanaflex®, generic available) Page(s): 63, and 65.

**Decision rationale:** Tizanidine 4 mg #120 is not medically necessary per MTUS guidelines. The MTUS recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic pain. Tizanidine (Zanaflex®, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. The documentation submitted does not reveal any indication of spasticity or low back pain or spasm that would require an antispasmodic. The request for Tizanidine 4 mg #120 is therefore not medically necessary.

**HYDROCODONE APAP10/325 MG #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, SHORT ACTING OPIOIDS

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines When to Discontinue Opioids and when to continue opioids Page(s): 79, 80.

**Decision rationale:** There is no indication that this medication has improved patient's pain or functioning to a significant degree therefore Hydrocodone/APAP is not medically necessary. The MTUS guidelines state to discontinue opioids if there is no overall improvement in function, unless there are extenuating circumstances, and to continue opioids if the patient has returned to work and if the patient has improved functioning and pain. Weaning was recommended on several prior utilization reviews per documentation for reasons of Hydrocodone/APAP not providing functional improvement or significant improvement in pain levels. The request for Hydrocodone/APAP is not medically necessary.

**OMEPRAZOLE 20 MG # 100:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

**Decision rationale:** Omeprazole 20mg #100 is not medically necessary per MTUS guidelines. Per MTUS guidelines Omeprazole is not medically necessary. There is no history that patient meets MTUS criteria for a proton pump inhibitor including : (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). California Medical Treatment Utilization Schedule Chronic Pain Guidelines do not support treatment Proton Pump Inhibitor medication in the absence of symptoms or risk factors for gastrointestinal disorders. Additionally, elsewhere in this review it was deemed that Naproxen was not medically necessary. Therefore the request for Omeprazole 20mg #100 is not medically necessary.