

Case Number:	CM13-0016191		
Date Assigned:	11/01/2013	Date of Injury:	03/25/2010
Decision Date:	02/20/2014	UR Denial Date:	07/08/2013
Priority:	Standard	Application Received:	08/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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 physician 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 42-year-old male with date of injury 03/25/2010. The patient initially presented with a right shoulder injury for which he eventually had a decompression on 12/20/2010. Since that time a number of other diagnoses have been added; 1 sleep loss, rule out obstructive sleep apnea, 2. Gastritis/gastroesophageal reflux disorder, 3. Right shoulder injury with myofascial pain syndrome, 4. Complaints of right-sided headaches, 5. Morbid obesity. The records indicate that the patient has been on the following medications since March of 2010: 1. Naproxen Sodium 550 Mg Tab SIG: Take 1 three times a day. 2. Omeprazole 20 Mg Tablet SIG: Take 1 twice daily. 3. Baclofen 10 Mg Tablet SIG: Take one tablet daily. Physical exam on 06/21/2013 as recorded by [REDACTED] "his blood pressure today remains elevated at 160/104 with a pulse of 93 using a large cuff. His weight remains near our scale maximum at now 372 pounds. He has dysesthesia and hyperesthesia around the right shoulder, decreased range of motion including abduction, flexion, reduced approximately 70°, with increased reports of pain from 20° on in flexion and abduction.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol HCL 50mg #20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 113. Decision based on Non-MTUS Citation ODG, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. There is no documentation of functional improvement supporting the continued long-term use of opioids.

Omeprazole DR 20mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physicians' Desk Reference (PDR)

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

Decision rationale: Clinicians should weigh 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 gastroduodenal lesions.

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 $\hat{1}$ /₄g 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). There is no documentation that the patient has any the risk factors needed to recommend a proton pump inhibitor.

Baclofen 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

Decision rationale: ODG recommends non-sedating muscle relaxants with caution as a second-line option for acute LBP and for short-term pain relief in patients with chronic LBP. Patient has been taking baclofen for nearly three years. Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in

combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen.