

<b>Case Number:</b>	CM13-0031128		
<b>Date Assigned:</b>	12/04/2013	<b>Date of Injury:</b>	08/04/2011
<b>Decision Date:</b>	02/21/2014	<b>UR Denial Date:</b>	09/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2013

### 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 Pain Management, has a subspecialty in Disability Evaluation 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 48-year-old female who reported an injury on 8/4/2011 which she attributed to repetitive reaching, pushing, pulling and lifting while working with machines. She is diagnosed with right lateral epicondylitis, right shoulder impingement syndrome, and right knee internal derangement. The patient complained of pain in her right shoulder and knee. She was initially treated with physical therapy sessions and oral medications. She had also been prescribed a knee brace and a TENS unit. Celestone/ Marcaine injection was administered to the patient's right elbow on 12/20/2012. Cortisone injection to her right knee was completed on January 2013. At the office visit on 2/22/2013, the patient complained of continuous right arm pain and right knee pain. Physical exam revealed tenderness and restricted ranges of motion for the right shoulder and right knee. On 8/2/2013, the patient complained of daily and continuous pain in the right shoulder. She also had pain in the right elbow that increases with gripping. Right knee pain was also reported.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Protonix, 20mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs; Cardiovascular and GI Complications.

**Decision rationale:** Protonix is recommended with precautions in patients taking NSAID, because of potential development of gastro-intestinal bleeding. The most recent medical records do not note any gastrointestinal complaints or findings suggestive of increased risk for an adverse gastrointestinal event in this patient. There is no indication for continued use of Protonix at this time. Chronic Pain Medical Treatment Guidelines page 68 (MTUS -Effective July 18, 2009) states that clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. They should 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).

**Motrin, 800mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 22,68-69.

**Decision rationale:** Anti-inflammatory items such as NSAIDS are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. For acute exacerbations of chronic pain NSAIDS are recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDS are more effective than acetaminophen for acute LBP. (Van Tulder, 2006) (Hancock, 2007). With regards to back pain with sciatica, a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain, this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. (Roelofs-Cochrane, 2008) The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. (Hancock, 2007). A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review of the medical records show that the patient continue to have pain despite taken multiple and different NSAIDs. There is no documented functional improvement to justify longer use NSAIDs in this patient.