

Case Number:	CM13-0040262		
Date Assigned:	03/21/2014	Date of Injury:	01/15/2008
Decision Date:	05/12/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	10/29/2013

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 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 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 an employee of [REDACTED] and has filed a claim for carpal tunnel syndrome, bucket-handle tear of the medial meniscus, and brachial neuritis/radiculitis associated with an industrial injury date of January 15, 2008. Utilization review from October 17, 2013 denied the requests for Flexeril due to chronic use, Naprosyn due to chronic use without evidence of acute exacerbation of pain, omeprazole due to no evidence of high risk for GI disease or complaints, and trazodone due to no rationale given for prescription and issues of noncompliance. Treatment to date has included oral pain medications, physical therapy, steroid injections to the shoulder, trigger point injection, and left shoulder surgery. Medical records from 2008 through 2014 were reviewed showing the patient complaining of persistent neck pain with associated paracervical muscle spasms, right greater than left. The spasms affect mobility of his neck and head. The patient would be unable to perform exercise activities and activities of daily living without medications. The pain is rated at 5/10 with medications and up to 9/10 without medications. On examination, there was noted muscle spasms and myofascial trigger points over the cervical spine area. Range of motion for the cervical spine was noted to be restricted. There is numbness into the left upper extremity along the C6 dermatomal pattern. The lumbar paraspinal musculature was noted to be tight. There were reports of numbness and tingling into the lower extremity on the right, which extends into the leg and into the knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLEXERIL 7.5 MG #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, Cyclobenzaprine, 41-42

Decision rationale: As stated on pages 41-42 of the California MTUS Chronic Pain Medical Treatment Guidelines, cyclobenzaprine is recommended as an option as a short course therapy for management of back pain. In this case, the patient has been using Flexeril since 2008. Other muscle relaxants were also interchanged since then such as Zanaflex, but the patient has recently been on Flexeril once again since December 2013 up to the February 2014 progress note. Long-term use is not supported; the need for variance from the guidelines is not clear. Therefore, the request for Flexeril is not medically necessary.

NAPROSYN 550 MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-68.

Decision rationale: As stated on pages 67-68 of the California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are useful in treating breakthrough and mixed pain conditions such as neuropathic pain, osteoarthritis, and back pain; there is no evidence for long-term effectiveness for pain and function. In this case, the patient's use of Naprosyn can be traced back as far as 2008. Although there are noted functional gains with the use of medications, the patient also complains of gastritis, which may be attributed to chronic Naprosyn use. In addition, there is no support for long-term use of this medication. Therefore, the request for Naprosyn is not medically necessary.

OMEPRAZOLE 20 MG #30: Upheld

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

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

Decision rationale: As stated on page 68 of the California MTUS Chronic Pain Medical Treatment Guidelines, proton pump inhibitors are recommended for patients who are at high risk for gastrointestinal events. In this case, the patient has been using omeprazole since 2008. While the patient does complain of gastrointestinal symptoms, the continued use of omeprazole for over 5 years without reevaluation of the adverse effect and the potential risks versus benefits is not

recommended. In addition, medical necessity was not present for the concurrent request for Naprosyn, which may alleviate the continued symptoms of gastritis. Therefore, the request for omeprazole is not medically necessary.

TRAZODONE 50 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 13.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS.
Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN,
INSOMNIA TREATMENT

Decision rationale: The CA MTUS does not address this topic specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Pain, Insomnia treatment was used instead. ODG states that trazodone has been used to treat insomnia and may be an option in patients with coexisting depression. In this case, the use of trazodone can be used as far back as August 2013. Trazodone is being prescribed for insomnia and depression. However, the patient is also on currently taking another antidepressant medication, namely Cymbalta. There is no discussion concerning the patient's sleep hygiene and education. Therefore, the request for trazodone is not medically necessary.