

<b>Case Number:</b>	CM13-0069470		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	06/18/2008
<b>Decision Date:</b>	04/28/2014	<b>UR Denial Date:</b>	12/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2013

### 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 Pain Medicine and is licensed to practice in Texas. 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 42-year-old male who reported an injury on 06/18/2008. The mechanism of injury was not stated. The patient is currently diagnosed with right elbow sprain, status post right elbow surgery, lateral epicondylitis, left shoulder sprain, sleep deprivation, anxiety/stress, insomnia, left shoulder rotator cuff tear, and gastric irritation. The patient was seen by [REDACTED] on 10/24/2013. The patient reported ongoing 5/10 right elbow and left shoulder pain. The patient also reported acid reflux, sleep issues, and stomach irritation. Physical examination on that date revealed slight swelling and bulging of the right elbow, painful range of motion of the right elbow, tenderness at the trapezius muscle, tenderness at the acromioclavicular joint, painful range of motion of the shoulder, and positive Neer and Hawkins testing. Treatment recommendations included a prescription for tramadol 50 mg, ranitidine 150 mg, and alprazolam 0.5 mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HYDROCODONE 5/325MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. According to the documentation submitted, the patient currently utilizes tramadol 50 mg, ranitidine 150 mg, and alprazolam 0.5 mg. There is no evidence of this patient's active utilization of this medication. Therefore, the request cannot be determined as medically appropriate. As such, the request is non-certified.

**RANITIDINE HCL 150MG:** 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 Page(s): 68-69.

**Decision rationale:** California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID. According to the documentation provided, the patient has previously utilized this medication. Despite ongoing use, the patient reports ongoing acid reflux and stomach irritation. There is no evidence of cardiovascular disease. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

**TRAMADOL 50MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. As per the documentation submitted, there is no evidence of a failure to respond to non-opioid analgesics prior to the initiation of an opioid medication. Therefore, the request cannot be determined as medically appropriate. As such, the request is non-certified.

**ALPRAZOLAM 0.5GM:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

**Decision rationale:** California MTUS Guidelines state benzodiazepines are not recommended for long-term use, because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit the use to 4 weeks. According to the documentation provided, the patient has utilized alprazolam 0.5 mg since at least 03/2013. There is no documentation of objective improvement. Guidelines do not recommend long-term use of this medication. California MTUS Guidelines further state a more appropriate treatment for anxiety disorder is an antidepressant. Based on the clinical information received and California MTUS Guidelines, the request is non-certified.

**ZOLPIDEM TARTRATA 5MG:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment

**Decision rationale:** Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. There is no evidence of this patient's active utilization of this medication. There is also no quantity listed in the current request. Therefore, the request is not medically appropriate. As such, the request is non-certified.

**KETOPROFEN 100%:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The only FDA approved topical NSAID is diclofenac. Therefore, the current request cannot be determined as medically appropriate. There is also no quantity listed in the current request. Based on the clinical information received, the request is non-certified.