

<b>Case Number:</b>	CM14-0105272		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	06/26/2012
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	06/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/08/2014

### 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 claimant was injured on 06/26/12. Anaprox, Norco, Prilosec, and Soma are under review. She was diagnosed with a sprain of her wrist and hand and complains of persistent neck and left shoulder pain with swelling of the left wrist. She had pain in the left shoulder with motion and generalized weakness. There was evidence of impingement and decreased range of motion which was mild to moderate. She had a well-healed scar of the left wrist on a soft mass palpated over the scar. Left wrist range of motion was mildly decreased. She was diagnosed with rotator cuff tendinitis with impingement syndrome and sprain of left wrist with dorsal ganglion cyst. She also left thumb and index finger triggering. She was referred to a hand specialist and for left shoulder open subacromial decompression and postop PT. She was given a cold unit, Anaprox, Norco, Prilosec, and Soma. She saw [REDACTED] on 05/12/14 for reevaluation of her pain. She complained of pain in the neck, both shoulders, elbows, wrists, and hands. She was also seen on 03/06/14. A second opinion with a hand surgery surgeon and authorization for left shoulder surgery and PT were recommended. At that time, she was prescribed Anaprox, Flexeril, Norco, and Protonix for relief of stomach upset.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Anaprox 550mg #60 (dispensed 5/12): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs (NSAIDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs; Medications for Chronic Pain Page(s): 101; 94.

**Decision rationale:** The history and documentation do not objectively support the request for Anaprox 550 mg #60 dispensed on 5/12. The MTUS state "NSAIDs (non-steroidal anti-inflammatory drugs) - Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Back Pain -Acute exacerbations of chronic pain: 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) ." Additionally, MTUS and ODG state "relief of pain with the use of medications is generally temporary and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medication should show effects within 1 to 3 days." The claimant also received this medication in March 2014 but had ongoing pain. There is no evidence that she tried and failed use of acetaminophen prior to receiving this medication and there is no objective measurable functional improvement documented in the records that has been shown to be due to the ongoing use of this medication. The medical necessity of the continued use of Anaprox 550 mg #60 has not been demonstrated.

**Retrospective Norco 10-325mg #60 (dispensed 5/12): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain; Medications for Chronic Pain Page(s): 110; 94.

**Decision rationale:** The history and documentation do not objectively support the request for the opioid, Norco 10/325 mg #60 dispensed on 5/12. The MTUS outlines several components of initiating and continuing opioid treatment and states "a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." In these records, there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as acetaminophen or non-steroidal anti-inflammatory drugs. MTUS further explains, "pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how

long it takes for pain relief; and how long pain relief lasts." Additionally, MTUS and ODG state "relief of pain with the use of medications is generally temporary and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medication should show effects within 1 to 3 days..." There is also no indication that periodic monitoring of the claimant's pattern of use and a response to this medication, including assessment of pain relief and functional benefit, has been or will be done. There is no evidence that she has been involved in an ongoing rehab program to help maintain any benefits she received from treatment measures. Additionally, the 4A's "analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors" should be followed and documented per the guidelines. The claimant's pattern of use of Norco is unclear other than she takes it. There is no evidence that a signed pain agreement is on file at the provider's office and no evidence that a pain diary has been recommended and is being kept by the claimant and reviewed by the prescriber. As such, the medical necessity of the ongoing use of Norco 10/325 mg #60 has not been clearly demonstrated. This request is not medically necessary.

**Retrospective Prilosec 20mg #60 (dispensed 5/12): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PROTON PUMP INHIBITORS Page(s): 102.

**Decision rationale:** The history and documentation do not objectively support the request for Protonix 20 mg #60 on 5/12. The MTUS state re: PPIs, "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 g four times daily) or (2) a Cox-2 selective agent. In this case, there is no documentation of GI conditions or increased gastrointestinal risk to support the use of this medication. The medical necessity of this request for Protonix 20 mg #60 has not been clearly demonstrated.

**Retrospective Soma 350mg #60 (dispensed 5/12): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL; MEDICATIONS FOR CHRONIC PAIN Page(s): 60; 94.

**Decision rationale:** The history and documentation do not objectively support the request for Soma 350 mg #60 dispensed on 5/12. The MTUS state on p. 60 that carisoprodol is "not

recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. In regular abusers the main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. This includes the following: a) increasing sedation of benzodiazepines or alcohol; b) use to prevent side effects of cocaine; c) use with tramadol to produce relaxation and euphoria; d) as a combination with hydrocodone, an effect that some abusers claim is similar to heroin (referred to as a "Las Vegas Cocktail"); & e) as a combination with codeine (referred to as "Soma Coma"). (Reeves, 1999) (Reeves, 2001) (Reeves, 2008) (Schears, 2004) There was a 300% increase in numbers of emergency room episodes related to carisoprodol from 1994 to 2005. (DHSS, 2005) Intoxication appears to include subdued consciousness, decreased cognitive function, and abnormalities of the eyes, vestibular function, appearance, gait and motor function. Intoxication includes the effects of both carisoprodol and meprobamate, both of which act on different neurotransmitters. (Bramness, 2007) (Bramness, 2004) A withdrawal syndrome has been documented that consists of insomnia, vomiting, tremors, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. This is similar to withdrawal from meprobamate. (Reeves, 2007)" Additionally, MTUS and ODG state "relief of pain with the use of medications is generally temporary and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication." In this case, there is no evidence of spasm to support the continued use of Soma. The claimant's pattern of use of this medication is unclear and there is no objective measurable evidence of functional improvement based on the use of Soma. The medical necessity of ongoing use of Soma 350 mg #60 for chronic complaints has not been clearly demonstrated. This request is not medically necessary.