

<b>Case Number:</b>	CM14-0012735		
<b>Date Assigned:</b>	04/23/2014	<b>Date of Injury:</b>	06/26/2012
<b>Decision Date:</b>	05/27/2014	<b>UR Denial Date:</b>	01/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/31/2014

### 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 Physical Medicine & Rehabilitation 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:

This 35 year-old patient sustained an injury on 6/26/12. Report of 12/16/13 from the provider noted patient with persistent pain in the neck, bilateral shoulders, left elbow, bilateral wrists and hands. Exam of left shoulder showed flexion/abd/internal rotation/external rotation of 160/160/60/60 degrees; positive Hawkins and Neer's testing; generalized weakness throughout motion; left wrist with tenderness about dorsal aspect; ext/flex and ulnar/radial deviation at 20/40 and 5 degrees; left hand triggering in thumb and index. Diagnoses included left shoulder rotator cuff tendinitis and impingement syndrome; left wrist sprain/strain with dorsal ganglion cyst; and triggering of left thumb and index finger. Treatment plan included medications above.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ANAPROX 550MG 1 TABLET TWICE DAILY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-Steroidal Anti-Inflammatory Drugs Page(s): 22.

**Decision rationale:** nti-inflammatories 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.

Monitoring of the NSAID's functional benefit is advised as long term use of NSAIDS beyond a few weeks may actually retard muscle and connective tissue healing. Available reports submitted have not adequately addressed the indication to continue this NSAID for an injury of 2012 nor its functional efficacy derived from treatment already rendered. There is no report of acute flare or new injuries. NSAIDs is a second line medication after use of acetaminophen. The Anaprox 550mg 1 tablet twice daily is not medically necessary and appropriate.

**FLEXERIL 7.5 MG 1 TABLET 3 TIMES DAILY #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41, 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

**Decision rationale:** Guidelines do not recommend long-term use of this muscle relaxant for this chronic injury of 2012. Additionally, the efficacy in clinical trials has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Submitted reports have not adequately demonstrated the indication or medical need for this treatment and there is no report of significant clinical findings, acute flare-up or new injury to support for its long-term use. There is no report of functional improvement resulting from its previous treatment to support further use as the patient remains with persistent unchanged chronic pain symptoms and clinical findings. The Flexeril 7.5 mg 1 tablet 3 times daily #90 is not medically necessary and appropriate.

**NORCO 10-325 1 TABLET BY MOUTH EVERY 6-8 HRS. AS NEEDED FOR PAIN #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in work status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document

for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain. The Norco 10-325 1 tablet by mouth every 6-8 hrs. as needed for pain #120 is not medically necessary and appropriate.

**PROTONIX 20 MG 1 TABLET TWICE DAILY #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 68-69.

**Decision rationale:** Protonix medication is for treatment of the problems associated with erosive esophagitis from GERD, or in patients with hypersecretion diseases. Per MTUS Chronic Pain Treatment Guidelines, the patient does not meet criteria for Protonix namely reserved for patients with history of prior GI bleeding, the elderly (over 65 years), diabetics, and chronic cigarette smokers. Submitted reports have not described or provided any GI diagnosis that meets the criteria to indicate medical treatment. Review of the records show no documentation of any history, symptoms, or GI diagnosis to warrant this medication. The Protonix 20 mg 1 tablet twice daily #60 is not medically necessary and appropriate.