

<b>Case Number:</b>	CM14-0018802		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	12/17/2010
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	02/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 Internal Medicine and is licensed to practice in District of Columbia and Virginia. 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 is a 40 year old man who sustained injury, on Dec 17 2010, to his right wrist and lower back after lifting a heavy steel flange. On Feb 17 2011, he tripped over a concrete skid and landed on his left hip and left shoulder. He had an MRI of the pelvis on Mar 4 2011 and CT scan of the abdomen on Mar 11 2011. On Aug 22 2013, [REDACTED] saw the patient for upper and lower back pain. He was diagnosed with chronic myofascial pain syndrome, bilateral S1 radiculopathy and a brachial plexus injury. The patient was prescribed flexeril, hydrocodone/APAP, remeron. He was instructed to obtain a urine drug screen and continue home aquatic therapy exercises. On Nov 15 2013, [REDACTED] saw the patient for upper and lower back pain. He was prescribed naproxen, fluoxetine and flexeril. On Dec 9 2013, [REDACTED] saw the patient for upper and lower back pain. The patient was instructed to obtain MRI of the lumbar spine and elbow and EMG/NCV of the lower extremities. The patient also saw [REDACTED], orthopedist, who had recommended some imaging studies. On Jan 20 2014, [REDACTED] saw the patient for upper and lower back pain. He was prescribed Naprosyn, hydrocodone/APAP, flexeril, Xanax. EMG/NCV was found to be normal.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NAPROXEN 550MG, #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 66, 72.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66, 72.

**Decision rationale:** Per MTUS guidelines, Naproxen Naproxen (Naprosyn): delayed release (EC-Naprosyn), as Sodium salt (Anaprox, Anaprox DS, Aleve [otc]) Generic available; extended-release (Naprelan): 375 mg. Different dose strengths and formulations of the drug are not necessarily bioequivalent. Dosing Information:Osteoarthritis or ankylosing spondylitis: Dividing the daily dose into 3 doses versus 2 doses for immediate-release and delayed-release formulations generally does not affect response. Morning and evening doses do not have to be equal in size. The dose may be increased to 1500 mg/day of naproxyn for limited periods when a higher level of analgesic/anti-inflammatory activity is required (for up to 6 months). Naprosyn or naproxyn: 250-500 mg PO twice daily. Anaprox: 275-550 mg PO twice daily. (total dose may be increased to 1650 mg a day for limited periods). EC-Naprosyn: 375 m g or 500 m g twice daily. The tablet should not be broken, crushed or chewed to maintain integrity of the enteric coating. Naprelan: Two 375 mg tablets (750 mg) PO once daily or two 500 mg tablets (1000 mg) once daily. If required (and a lower dose was tolerated) Naprelan can be increased to 1500 mg once daily for limited periods (when higher analgesia is required). Pain: Naprosyn or naproxyn: 250-500 mg PO twice daily. The maximum dose on day one should not exceed 1250 m g and 1000 m g on s ubsequent days. Anaprox: 275-550 mg PO twice daily. The maximum dose on day one should not exceed 1375 mg and 1100 mg on subsequent days. Extended-release Naprelan: Not recommended due to delay in absorption. (Naprelan Package Insert)The lowest dose for the shortest period for osteoarthritis pain at a maximum of 1100mg per day and this can be continued for six weeks. The patient was prescribed this medication for over this time frame from review of the literature. The request for Naprozen 550mg, #120 is not medically necessary and appropriate.

**URINE DRUG SCREEN:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria For The Use Of Opioids Page(s): 77.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 77-78.

**Decision rationale:** Per MTUS, Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. For more information, see Opioids, criteria for use: (2) Steps to Take Before a Therapeutic Trial of Opioids & (4) On-Going Management; Opioids, differentiation: dependence & addiction; Opioids, screening for risk of addiction (tests); & Opioids, steps to avoid misuse/addiction. Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. This patient was given hydrocodone/APAP for pain issues. He had no documented issues of drug abuse or addiciton. Therefore, the request for urine drug screen is not medically necessary and appropriate.

**XANAX 0.5MG, #60:** Upheld

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

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

**Decision rationale:** Per MTUS, Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005). From the clinical documentation provided, the patient did not appear to have issues with anxiety. It is not clear what benefit he would have from this medication. Therefore, the request for Xanax 0.5mg #60 is not medically necessary.