

<b>Case Number:</b>	CM14-0188085		
<b>Date Assigned:</b>	11/18/2014	<b>Date of Injury:</b>	09/15/2008
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	10/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/11/2014

### 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 New York. 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 year old female with a date of injury of 09/15/2008. She had accumulated trauma that led to bilateral shoulder injuries. She has been treated with physical therapy, Norco, Zanaflex, Celebrex, Ultracet, Ativan and Valium. On 04/07/2009 a left upper extremity EMG/NCS was normal. On 06/30/2010 she had right shoulder arthroscopic surgery. On 04/26/2011 she had another normal EMG/NCS. On 09/10/2011 she had a right shoulder MRI that revealed the previous rotator cuff repair and she had mild bursitis. On 10/29/2013 a left upper extremity EMG/NCS was normal despite left upper extremity symptoms. On 09/24/2014 she was taking Noroc, Zanaflex, Celebrex, Ativan and Valium. Gait was normal. The right shoulder range of motion was decreased. Hawkins test was positive. Empty can test was positive. There was tenderness to palpation. The left shoulder range of motion was decreased. The Hawkins, Neer and empty can tests were positive. Strength was either 5/5 or 5-/5.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Celebrex 200mg # 300:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines COX-2 NSAIDS.

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

**Decision rationale:** Chronic Pain Medical Treatment Guidelines 8 9792.26 California Medical Treatment Utilization Schedule (MTUS) (Effective July 18, 2009) Page 67. NSAIDs (non-steroidal anti-inflammatory drugs) Specific recommendations: Osteoarthritis (including knee and hip): 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. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008). California MTUS does not support long term NSAIDS for this patient's clinical presentation.

**Flexeril 7.5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-64, 70, 78, 124.

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

**Decision rationale:** Chronic Pain Medical Treatment Guidelines (Effective July 18, 2009) Page 63. Muscle relaxants (for pain) recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic lower back pain (LBP). (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. (Chou, 2004) According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. (See2, 2008). Continued use of muscle relaxants is not consistent with California Medical Treatment Utilization Schedule (MTUS) guidelines.

