

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM14-0206572 |                              |            |
| <b>Date Assigned:</b> | 12/18/2014   | <b>Date of Injury:</b>       | 08/29/2012 |
| <b>Decision Date:</b> | 02/10/2015   | <b>UR Denial Date:</b>       | 12/05/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/10/2014 |

### 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 claimant is a 51 yo male who sustained an industrial injury on 08/29/2012. The mechanism of injury was not provided for review. His diagnoses include left shoulder pain- status post left shoulder arthroscopy with rotator cuff repair and low back pain. He continues to complain of left shoulder, low back pain, and myofascial pain syndrome. On physical exam there are trigger points noted in the left trapezius, rhomboids, and paracervical muscles. There is decreased range of motion of the neck and left shoulder. Treatment in addition to surgery has included medical therapy and physical therapy. The treating provider has requested a urine drug screen, Naprosyn 550mg, Omeprazole 20mg, Flexeril 7.5mg, Neurontin 600mg, Methoderm Gel 120gm #2 with 1 refill, and additional physical therapy twice weekly for the cervical spine and left shoulder Qty: 8.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Urine Drug Screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

**Decision rationale:** Per the MTUS Chronic Pain Management Treatment Guidelines, screening is recommended in chronic pain patients to differentiate dependence and addiction with opioids as well as compliance and potential misuse of other medications. Per the documentation, the claimant is presently not maintained on any opioid medications. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

**Naprosyn 550mg:** Overturned

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

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

**Decision rationale:** The requested medication, Naproxen Sodium 550mg is medically necessary for the treatment of the claimant's pain condition. Naproxen is a non-steroidal anti-inflammatory medication (NSAID). These medications are recommended for the treatment of chronic pain as a second line therapy after Acetaminophen. The documentation indicates the claimant has a chronic pain condition and the medication has proved beneficial for pain control. Medical necessity for the requested treatment has been established. The requested treatment is medically necessary.

**Omeprazole 20mg:** Upheld

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

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

**Decision rationale:** Per the MTUS Chronic Pain Medical Treatment Guidelines, proton pump inhibitors are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any symptoms or GI risk factors. GI risk factors include: age > 65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants or high dose/multiple NSAID. The claimant has no documented GI issues. Based on the available information provided for review, the medical necessity for Prilosec has not been established. The requested medication is not medically necessary.

**Flexeril 7.5mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

**Decision rationale:** According to the guidelines, Flexeril (Cyclobenzaprine) is not recommended for the long-term treatment of chronic pain. The medication has its greatest effect in the first four days of treatment. The documentation indicates there are no palpable muscle spasms and there is no documentation of functional improvement from any previous use of this medication. Per the California MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

**Neurontin 600mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13.

**Decision rationale:** Gabapentin is not medically necessary for the treatment of the patient's condition. Per the documentation, there is no evidence that the claimant has neuropathic pain. Per the MTUS Chronic Pain Medical Treatment Guidelines, anti-epilepsy medications are a first line treatment for neuropathic pain. A recommended trial period for an adequate trial of Gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. The patient has been prescribed the medication and there is no specific documentation of a positive response to this medical therapy. Therefore, this request is not medically necessary.

**Menthoderm gel 120gm QTY: 2 with 1 refill:** Upheld

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

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

**Decision rationale:** There is no documentation provided necessitating use of the requested topical medication. Per the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, gamma agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is no documentation of intolerance to other

previous treatments. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.

**Additional physical therapy twice weekly for the cervical spine and left shoulder QTY: 8:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

**Decision rationale:** Per the MTUS Chronic Pain Medical Treatment Guidelines, physical therapy is indicated for the treatment of neck and shoulder pain. Recommendations state that for most patients a total of 10 visits over a period of over 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. In this case the claimant has completed 12 physical therapy sessions with a reported good benefit but no specific documentation of increased function, decreased pain, or increased range of motion and strength. There is no specific indication for the additional sessions. Medical necessity for the requested additional physical therapy sessions has not been established. The requested treatment is not medically necessary.