

<b>Case Number:</b>	CM15-0109988		
<b>Date Assigned:</b>	06/16/2015	<b>Date of Injury:</b>	04/13/2011
<b>Decision Date:</b>	08/13/2015	<b>UR Denial Date:</b>	05/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/08/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 injured worker is a 56 year old male, who sustained an industrial injury on 4/13/2011. The current diagnoses are right knee medial meniscus tear plus chondromalacia of the patella, status post arthroscopic medial meniscectomy and chondroplasty patella of the right knee, left knee overuse syndrome plus chondromalacia of the patella, bilateral shoulder post-traumatic arthrosis of the acromioclavicular joints secondary to overuse, status post bilateral shoulder surgery, 4 millimeter herniated nucleus pulposus at C5-6, right wrist sprain, stress, depression, anxiety, insomnia, and gastroesophageal reflux disease. According to the progress report dated 4/30/2015, the injured worker complains of severe right shoulder pain, mild left shoulder pain, mild right wrist pain, and mild right knee pain. Per notes, he is 6 weeks post-surgery for right-sided decompressive and partial distal claviclectomy. The level of pain is not rated. The physical examination reveals restricted range of motion in the right shoulder. Hand grip is documented as 25/20/25. The current medications are Norco, Prilosec, Gabapentin, and Xanax. Treatment to date has included medication management, physical therapy, and surgical intervention. The plan of care includes prescriptions for Norco, Xanax, Prilosec, and Gabapentin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Norco 10/325mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91, 78-80, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97.

**Decision rationale:** According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there was no documentation of the medication's functional benefit, return to work, random drug testing, or opioid contract. Medical necessity of the requested item was not established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

**Retrospective Xanax 1mg #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 Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Benzodiazepines.

**Decision rationale:** According to CA MTUS Guidelines, benzodiazepines are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Xanax (Alprazolam) is a short-acting benzodiazepine, having anxiolytic, sedative, and hypnotic properties. Most guidelines limit use of this medication to four weeks. The MTUS does not recommend benzodiazepines for long term use for any condition. The medical documentation indicates the claimant has continued symptoms of depression with anxiety and sleep issues. The claimant is not maintained on any anti-depressant medication. Xanax was used for sleep. She would benefit from a mental health evaluation to determine the appropriate medical therapy for her depression, anxiety and sleep issues. Medical necessity for the requested medication, Xanax was not established. The requested treatment is not medically necessary.

**Retrospective Prilosec 20mg #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

**Decision rationale:** According to CA MTUS (2009), proton pump inhibitors, such as Omeprazole (Prilosec), 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 GI symptoms or GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation of any reported GI complaints. Based on the available information provided for review, the medical necessity for Prilosec was not established. The requested medication is not medically necessary.

**Retrospective Gabapentin 300mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 18-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 17-19, 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Gabapentin (Neurontin).

**Decision rationale:** According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. In this case, there is no documentation of subjective or objective findings consistent with neuropathic pain to necessitate use of Neurontin. Medical necessity for Neurontin was not established. The requested medication is not medically necessary.