

<b>Case Number:</b>	CM15-0054953		
<b>Date Assigned:</b>	03/30/2015	<b>Date of Injury:</b>	08/15/2013
<b>Decision Date:</b>	05/18/2015	<b>UR Denial Date:</b>	03/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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 38 year old female, who sustained an industrial injury on August 15, 2013. The injured worker was diagnosed as having right shoulder acromioclavicular osteoarthropathy, rule out rotator cuff pathology of the right shoulder, cervical myofascial pain, and rule out cervical disc injury/radiculopathy. Treatment to date has included physical therapy, activity modification, stretching, TENS, home exercises, cold, heat, and medication. Currently, the injured worker complains of right shoulder pain and cervical pain with increasing right upper extremity symptoms. The Primary Treating Physician's report dated February 23, 2015, noted tenderness in the right shoulder anterior aspect and at the AC, with impingement signs positive, positive Jobe test, and atrophy of the right deltoid musculature. Functional improvement, range of motion (ROM), and maintenance of activities of daily living (ADLs) was noted with medication on board. The Physician dispensed Tramadol ER, Naproxen Sodium, Pantoprazole, and Cyclobenzaprine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol ER (extended release) 150 mg Qty 60 (retrospective DOS 12/29/2014): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** According to the California MTUS, Tramadol ER is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness or functional improvement, and no clear documentation that the patient has responded to ongoing opioid therapy. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

**Naproxen sodium 55 mg Qty 90 (retrospective DOS 12/29/2014): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

**Decision rationale:** Naproxen is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute low back pain (LBP) and acute exacerbations of chronic pain, short-term pain relief in chronic LBP, and short-term improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, the patient had prior use of on NSAIDs without any documentation of significant improvement. There was no documentation of subjective or objective benefit from use of this medication. Medical necessity of the requested medication has not been established. The request for Naproxen is not medically necessary.

**Pantoprazole 20 mg Qty 90 (retrospective DOS 12/29/2014): Upheld**

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

**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 Pantoprazole (Protonix), 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. In addition, the request for continued use of NSAIDs (Naproxen) has been denied. Medical necessity for Protonix has not been established. The requested medication is not medically necessary.

**Cyclobenzaprine 7.5 mg Qty 90 (retrospective DOS 12/29/2014):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

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

**Decision rationale:** According to the reviewed literature, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. The medication has its greatest effect in the first four days of treatment. There is no documentation of functional improvement from any previous use of this medication. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than nonsteroidal 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.