

<b>Case Number:</b>	CM15-0080745		
<b>Date Assigned:</b>	05/01/2015	<b>Date of Injury:</b>	03/08/2012
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	04/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/27/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

### 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 59 year old female, who sustained an industrial injury on 03/08/2012. She has reported injury to the neck, left shoulder, left knee, and low back. The diagnoses have included sprain of neck; cervical disc displacement; cervical spondylosis; sprain of left shoulder; left shoulder partial rotator cuff tear; and sprain of left knee. Treatment to date has included medications, diagnostic studies, acupuncture, chiropractic therapy, and physical therapy. Medications have included Hydrocodone/Acetaminophen, Naprosyn, and Alprazolam. A progress note from the treating physician, dated 12/23/2014, documented a follow-up visit with the injured worker. Currently, the injured worker complains of left shoulder pain; pain limits movement of the left shoulder; and neck pain. Objective findings included diffuse tenderness to the left shoulder; left shoulder motor strength decreased due to pain; decreased left shoulder range of motion; and decreased cervical spine range of motion. Request is being made for Retrospective request for Hydrocodone/Acetaminophen 10/325mg #60, date of service 03/10/2015; Retrospective request for Naprosyn 550mg #60, date of service 03/10/2015; and Retrospective request for Alprazolam 0.5mg #60, date of service 03/10/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for Hydrocodone/APAP 10/325 #60 DOS 03/10/15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

**Decision rationale:** Retrospective request for Hydrocodone/APAP 10/325 #60 DOS 03/10/15 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS Chronic Pain Medical Treatment Guidelines state that a pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. There is no applicable progress note for the date of service 3/10/15. The documentation submitted does not reveal the above pain assessment or clear evidence of significant functional improvement on prior opioids therefore the request for Hydrocodone/APAP 10/325 #60 DOS 03/10/15 is not medically necessary.

**Retrospective request for Naprosyn 550mg #60 DOS 03/10/15:** Upheld

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

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

**Decision rationale:** The retrospective request for Naprosyn 550mg #60 DOS 03/10/15 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that NSAIDs are recommended as an option at the lowest dose for short-term symptomatic relief of chronic low back pain, osteoarthritis pain, and for acute exacerbations of chronic pain. The documentation indicates that the patient has been on NSAIDs for an extended period without evidence of functional improvement and with persistent pain. The MTUS states that there is no evidence of long-term effectiveness of NSAIDs for pain or function. Additionally NSAIDs have associated risk of adverse cardiovascular events, new onset or worsening of pre-existing hypertension, ulcers and bleeding in the stomach and intestines at any time during treatment, elevations of one or more liver enzymes may occur in up to 15% of patients taking NSAIDs and may compromise renal function. The documentation does not indicate an applicable progress note for the date of service 3/10/15. The request for continued Naproxen is not medically necessary. NSAIDs (non-steroidal anti-inflammatory drugs) page 67-73.

**Retrospective request for Alprazolam 0.5mg #60 DOS 03/10/15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 23.

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

**Decision rationale:** Retrospective request for Alprazolam 0.5mg #60 DOS 03/10/15 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that 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. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The documentation does not indicate evidence of functional improvement from prior use. There is no applicable progress note from DOS 3/10/15. The MTUS does not support this medication long term. The request for Alprazolam is not medically necessary.