

<b>Case Number:</b>	CM14-0179374		
<b>Date Assigned:</b>	11/03/2014	<b>Date of Injury:</b>	10/27/2002
<b>Decision Date:</b>	12/09/2014	<b>UR Denial Date:</b>	09/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2014

### 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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 67-year-old male who reported an injury on 10/27/2002 due to an unknown mechanism. Physical examination on 07/07/2014 revealed the injured worker was status post reverse total shoulder replacement on 12/14/2011. It also indicated that the patient had a history of gastritis and was on Protonix with good relief of symptoms. There were complaints of mid back, posterior, and shoulder spasms that were relieved with Flexeril. Examination revealed tenderness with range of motion of the left shoulder, pain on range of motion, spasm in the left postscapular thoracic area, and numbness and tingling in the left hand. The injured worker had a nerve conduction velocity test that revealed severe carpal tunnel syndrome in the left arm or hand. Diagnoses were sprained neck, sprained shoulder/arm, and sprained elbow/forearm. The rationale and Request for Authorization were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexeril 7.5mg, #90 dispensed on 08/25/14:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41, 64.

**Decision rationale:** The decision for Flexeril 7.5mg, #90 dispensed on 08/25/14 is not medically necessary. The California Medical Treatment Utilization Schedule states that cyclobenzaprine (Flexeril) is recommended for a short course of therapy. Flexeril is more effective than placebo in the management of back pain, however, the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. This medication is not recommended to be used for longer than 2 to 3 weeks. There is a lack of documentation of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug abuse behavior and side effects. The long term use of these medications should be based on measurements of pain relief and documented functional improvement. The medical guidelines do not recommend a long treatment course of Flexeril. Also, the request does not indicate a frequency for the medication. There were no other significant factors provided to justify the use outside of current guidelines. Therefore, this request is not medically necessary.

**Voltaren XR #60 x2 dispensed on 08/25/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 71.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 70.

**Decision rationale:** The decision for Voltaren XR #60 x2 dispensed on 08/25/14 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend the use of NSAIDs for injured workers with osteoarthritis (including knee and hip) and patients with acute exacerbations of chronic low back pain. The guidelines recommend NSAIDs at the lowest dose for the shortest period in injured workers with moderate to severe pain. Acetaminophen may be considered for initial therapy for injured workers with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular, or renovascular risk factors. In injured workers with acute exacerbations of chronic low back pain, the guidelines recommend NSAIDs as an option for short term symptomatic relief. The efficacy of this medication was not provided. There was no significant functional benefit reported from the use of this medication. Also, the request does not indicate a frequency for the medication. There is a lack of documentation of objective functional improvement. Continued use of this medication would not be supported. Therefore, this request is not medically necessary.

**Norco 10/325mg, #60 x2 dispensed on 08/25/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids regarding : Hydrocodone/Acetaminophen (Norco) ; On-Going M.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 78.

**Decision rationale:** The decision for Norco 10/325mg, #60 x2 dispensed on 08/25/14 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines

recommend providing ongoing education on both the benefits and limitations of opioid treatment. The guidelines recommend the lowest possible doses should be prescribed to improve pain and function. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The pain assessment should include current pain, the least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long the 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 provided medical documentation lacked evidence of the injured worker's failure to respond to nonopioid analgesics. The long term use of these medications should be based on measurements of pain relief and documented functional improvement without side effects or signs of aberrant use. There is a lack of documentation of objective functional improvement from the use of this medication. Therefore, this request is not medically necessary.

**Menthoderm Gel, 120ml x2 dispensed 8/25/2014: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals Page(s): 105.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic, Topical Salicylates Page(s): 111, 105.

**Decision rationale:** The decision for Mentoderm Ge,l 120ml x2 dispensed 8/25/2014 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. They further indicate that topical salicylates are appropriate for the treatment of pain. The efficacy of this medication was not reported. The request does not indicate a frequency for this medication. The medical guidelines state that topical analgesics are primarily recommended when antidepressants and anticonvulsants have failed. It was not reported within the documents submitted for review that the injured worker had a trial of any type of antidepressant or anticonvulsant. Therefore, this request is not medically necessary.