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| <b>Case Number:</b>   | CM13-0029935 |                              |            |
| <b>Date Assigned:</b> | 03/17/2014   | <b>Date of Injury:</b>       | 02/18/2012 |
| <b>Decision Date:</b> | 07/07/2014   | <b>UR Denial Date:</b>       | 09/18/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/25/2013 |

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 48-year-old male who reported an injury on 02/18/2012. The mechanism of injury is not provided within the documentation. His diagnoses were right rotator cuff tendinopathy, right SLAP tear, and right AC joint arthritis. His previous treatments were noted to be right shoulder arthroscopy, superior labral anterior-posterior debridement, rotator cuff repair using 2 anchors, subacromial decompression with bursectomy, and acromioplasty. These occurred on 02/25/2013. The injured worker noted during a physical examination on 05/15/2013 that he continues to improve slowly. The injured worker at the time of this examination completed 11 physical therapy sessions. He indicated his pain ranged up to 3/10 and this was improved from previous examinations. The treatment plan at that time was for the injured worker to continue physical therapy. Additional sessions twice a week for 3 weeks were indicated as requested. The patient was counseled on weaning himself off Norco and transitioning to ibuprofen. A document dated 06/10/2013 indicates the injured worker is still on Norco. The provider's rationale for the requested medications was not provided within the documentation. The request for authorization for medical treatment was not provided within the documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NAPROXEN SODIUM TABLETS 550 MG #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen Page(s): 66, 69.

**Decision rationale:** The request for naproxen sodium tablets 550 mg #120 is not medically necessary. The California MTUS, Chronic Pain Medical Treatment Guidelines indicate naproxen is a non-steroidal anti-inflammatory drug for the relief of the signs and symptoms of osteoarthritis. The injured worker's most recent clinical evaluation notes pain at 3/10. There are no other indicators within that assessment which might require an anti-inflammatory medication. The injured worker does not have a diagnosis of osteoarthritis. The guidelines indicate if long-term therapy of naproxen is required; the full dose 500 mg twice a day appears to be the preferred choice of NSAID. The request is for naproxen sodium tablets of 550 mg and it does not indicate a frequency. Therefore, the request for naproxen sodium tablets 550 mg #120 is not medically necessary.

**OMEPRAZOLE DELAYED- RELEASE CAPSULES 20MG #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI SYMPTOMS AND CARDIOVASCULAR RISK.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's, GI symptoms Page(s): 68.

**Decision rationale:** The request for omeprazole delayed release capsules 20 mg #120 is not medically necessary. The California MTUS, Chronic Pain Medical Treatment Guidelines recommend omeprazole for patients at intermediate risk for gastrointestinal events who use non-selective NSAIDs. The clinical evaluation on 05/15/2013 indicated the patient weaning from Norco to ibuprofen. However, the documentation provided does not indicate any gastrointestinal events of the injured worker. The provider's request does not indicate a frequency for the medication. It is noted in the documentation on 06/10/2013 that the patient was still using omeprazole, but there was no indication of the efficacy of that medication documented. Therefore, the request for omeprazole delayed release capsules 20 mg #120 is not medically necessary.

**TRAMADOL HYDROCHLORIDE ER 150MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE, ONGOING MANAGEMENT.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113, 75.

**Decision rationale:** The request for tramadol hydrochloride extended release 150 mg #90 is not medically necessary. The California MTUS, Chronic Pain Medical Treatment Guidelines

indicate that tramadol is a centrally-acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. The clinical documentation submitted for this review does not indicate any medications failed before prescribing tramadol. The guidelines indicate tramadol is effective in managing neuropathic pain. The clinical evaluation does not indicate the injured worker complaining of neuropathic pain. The pain rate at the time of evaluation on 05/15/2013 was 3/10. The injured worker was receiving a prescription for refill of tramadol on 06/10/2013. There is no documentation provided to indicate the efficacy of tramadol. The provider did not indicate a frequency for tramadol. Therefore, the request for tramadol hydrochloride extended release 150 mg #90 is not medically necessary.

**ONDANSETRON ODT TABLETS 8MG #30X2 QTY: 60: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Ondansetron.

**Decision rationale:** The request for Ondansetron ODT tablets 8 mg #30 x2 QTY: 60 are not medically necessary. The Official Disability Guidelines do not recommend Ondansetron for nausea and vomiting secondary to chronic opioid use. The most recent clinical evaluation submitted for this review dated 05/15/2013 does not indicate the injured worker having signs or symptoms of nausea. The provider's request for Ondansetron did not indicate a frequency. Therefore, the request for Ondansetron ODT tablets 8 mg #30 x2 QTY: 60 are not medically necessary.