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| <b>Case Number:</b>   | CM13-0063902 |                              |            |
| <b>Date Assigned:</b> | 12/30/2013   | <b>Date of Injury:</b>       | 12/20/2004 |
| <b>Decision Date:</b> | 04/15/2014   | <b>UR Denial Date:</b>       | 11/11/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/10/2013 |

### 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, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 patient is a 65-year-old female who reported an injury on 12/20/2004. The mechanism of injury was not specifically stated. The patient is diagnosed with right shoulder impingement, rotator cuff tear, rotator cuff tendinitis, and biceps tendinitis. The patient was seen by [REDACTED] on 10/30/2013. The patient reported ongoing pain in the right shoulder with weakness and stiffness. Physical examination revealed 150-degree forward flexion, 35-degree external rotation, 75-degree abduction, and 90-degree internal rotation. The patient also demonstrated weakness and positive impingement testing. Treatment recommendations included continuation of current medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Two (2) month trial of a TENS XP unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1

month home based TENS trial may be considered as a non-invasive conservative option. There is no documentation of a failure to respond to other appropriate pain modalities. The request for a 2 month trial of a TENS unit exceeds Guideline recommendations. There was also no documentation of a treatment plan including the specific short and long-term goals of treatment with the unit. Based on the clinical information received, the prospective request for a two (2) month trial of a TENS XP unit is non-certified.

**Anaprox 550mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Guidelines state Non-steroidal anti-inflammatory drug (NSAIDs) are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, Non-steroidal anti-inflammatory drug (NSAIDs) are recommended as a second line treatment after acetaminophen. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain, weakness, and stiffness. Satisfactory response to treatment has not been indicated. Therefore, the prospective request for Anaprox 550mg is non-certified.

**Zofran:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

**Decision rationale:** The Official Disability Guidelines state Zofran is not recommended for nausea and vomiting secondary to chronic opioid use. Zofran is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment, and has also been approved for postoperative use. The patient does not appear to meet criteria for the requested medication. As such, the prospective request for Zofran is non-certified.

**Prilosec 20mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective Non-steroidal anti-inflammatory drug (NSAID). There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, the prospective request for Prilosec 20mg is non-certified.

**Hydrocodone 10/325mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. There is no documentation of a satisfactory response to treatment. Therefore, the prospective request for Hydrocodone 10/325mg is non-certified.

**Menthoderm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Guidelines state salicylate topicals such as methyl salicylate are recommended, and are significantly better than placebo in chronic pain. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain, stiffness, and weakness. Based on the clinical information received, ongoing use cannot be determined as medically appropriate. As such, the prospective request for Menthoderm is non-certified.