

<b>Case Number:</b>	CM14-0002180		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	03/29/2001
<b>Decision Date:</b>	07/28/2014	<b>UR Denial Date:</b>	12/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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 Occupational Medicine and is licensed to practice in California. 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 56-year-old female who has filed a claim for adhesive capsulitis associated with an industrial injury date of March 29, 2001. Review of progress notes indicates increased right shoulder pain. Findings include decreased cervical spine and shoulder range of motion, decreased motor strength upon right shoulder abduction and flexion, positive impingement sign, positive Tinel's at the right wrist and elbow, and tenderness over the lateral more than the medial elbow. EMG/NCV performed in June 05, 2001 showed right carpal tunnel, moderate. Patient has a history of gastrointestinal problems due to the early use of high dose NSAIDs. Reports note that the current medication regimen of Norco, Skelaxin, Prilosec, ibuprofen, and Voltaren Gel have been effective in maintaining a high level of function with no signs of side effects, such as narcotic abuse or recurrent gastritis or ulcers. The patient is currently working as an ultrasound technician with full responsibilities. Treatment to date has included acetaminophen, NSAIDs, opioids, muscle relaxants, TENS, ice/heat, physical therapy, and bilateral shoulder surgeries. Utilization review from December 20, 2013 denied the requests for Norco as there was no documentation of continued benefit or of medication monitoring; Skelaxin was denied as this medication is not recommended for chronic use; and Voltaren Gel 1% as there was no documentation of failed trials with antidepressants and anticonvulsants, and the efficacy of topical NSAIDs has been inconsistent.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; On-Going Management Page(s): 78-82.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines, state there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, the patient has been on this medication since at least April 2013. However, there is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication, or of periodic urine drug screens to monitor medication use. The requested quantity and dosage is not specified. Therefore, the request for Norco is not medically necessary and appropriate.

**Skelaxin:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. They may be effective in reducing pain and muscle tension, and increasing mobility. However, they show no benefit beyond NSAIDs in pain and overall improvement. In this case, the patient has been on this medication since March 2005. There is no documentation of acute exacerbations of pain, or of muscle spasms, to support the continued use of this medication. Also, this medication is not recommended for chronic use, and the requested quantity and dosage is not specified. Therefore, the request for Skelaxin is not medically necessary and appropriate.

**Prilosec:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

**Decision rationale:** According to the MTUS Chronic Pain Medical Treatment Guidelines, proton pump inhibitors are used in patients on NSAID therapy who are at risk for GI events. Risk factors includes age > 65; history of peptic ulcer, GI bleed, or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; and high dose or multiple NSAID use. Use of PPI > 1 year has been shown to increase the risk of hip fracture. Patient has been on this medication since

at least April 2013. In this case, the patient has a history of gastritis due to early use of high-dose NSAIDs. As the patient will be continued on oral NSAID therapy, concurrent use of a proton pump inhibitor is medically necessary. However, the requested quantity and dosage is not specified. Previous utilization review determination, dated December 20, 2013, has already certified this request for Prilosec 20mg, 3 month supply. Therefore, the request for Prilosec is not medically necessary and appropriate.

**Ibuprofen:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (nonsteroidal anti-inflammatory drugs) Page(s): 67-69.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and there is no evidence of long-term effectiveness for pain or function. In this case, the patient has been on this medication since at least April 2013. Progress notes indicate that the patient has been able to continue working with full duties with the current medication regimen. Continuing this medication is reasonable at this time as it is able to maintain tolerable pain levels and a high level of functioning in this patient. However, the requested dosage and quantity is not specified. Previous utilization review determination, dated December 20, 2013, has already certified this request for ibuprofen 200mg, 3 month supply. Therefore, the request for ibuprofen is not medically necessary and appropriate.

**Voltaren Gel:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines, Voltaren gel is indicated for relief of osteoarthritis pain in the joints that lend themselves to topical treatment which includes the ankles, elbows, feet, hands, knees, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. In this case, the patient has been on this medication since October 2013. The patient is already on oral NSAID therapy, and there are no guidelines established to support the use of Voltaren Gel for the shoulder. Also, the requested quantity is not specified. Therefore, the request for Voltaren Gel is not medically necessary and appropriate.