

<b>Case Number:</b>	CM14-0023638		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	08/04/2000
<b>Decision Date:</b>	07/15/2014	<b>UR Denial Date:</b>	01/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2014

### 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 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 injured worker is a 64-year-old female injured on 08/04/00 due to an undisclosed mechanism of injury. Current diagnoses include right shoulder rotator cuff syndrome and status post bilateral knee arthroscopies with early degenerative changes. Clinical note dated 04/22/14 indicates the injured worker is three months status post right knee surgery and five months status post left knee surgery. It is noted that the injured worker underwent partial meniscectomies with noted osteoarthritis in bilateral knees. Physical examination of the right shoulder revealed decreased range of motion, strength 5/5 of the rotator cuff, positive impingement sign, negative external rotation lag test, and normal sensation. Examination of the bilateral knees revealed tenderness along the patellar tendon on the right, full range of motion, mild joint line tenderness primarily medially bilaterally, and stable with negative Lachman's test. Treatment plan includes request for Orthovisc and subacromial injection to the right shoulder. The injured worker is also advised to continue with a home exercise program which included pool therapy. The initial request for Voltaren 1% topical cream, Ambien, and Lansoprazole was initially non-certified on 01/26/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**VOLTAREN 1% TOPICAL CREAM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
TOPICAL ANALGESICS Page(s): 112.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN (CHRONIC), VOLTAREN GEL (DICLOFENAC).

**Decision rationale:** As noted in the Pain chapter of the Official Disability Guidelines, Voltaren Gel is not recommended as a first-line treatment. Voltaren Gel is recommended for osteoarthritis after failure of an oral NSAID, contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations. According to FDA MedWatch, post-marketing surveillance of Voltaren Gel has reported cases of severe hepatic reactions, including liver necrosis, jaundice, fulminant hepatitis with and without jaundice, and liver failure. As such, the request for Voltaren 1% topical cream cannot be recommended as medically necessary at this time.

**AMBIEN CR 12.5 #30 TIMES 2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Hypnotic Page(s): 112.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) - ONLINE VERSION, PAIN (CHRONIC), ZOLPIDEM (AMBIEN).

**Decision rationale:** As noted in the Pain (Chronic) of the Official Disability Guidelines (ODG), online version, Ambien is approved for the short-term (usually two to six weeks) treatment of insomnia. Pain specialists rarely, if ever, recommend it for long-term use. Ambien can be habit-forming, and may impair function and memory more than opioid pain relievers. There is also concern that it may increase pain and depression over the long-term. The injured worker has been utilizing this medication on a long-term basis, exceeding the recommended 2-6 week window of use. As such, the request for Ambien CR 12.5 #30 times two cannot be recommended as medically necessary.

**LAINSOPRAZOLE 30MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, PROTON PUMP INHIBITORS.

**Decision rationale:** As noted in the Official Disability Guidelines, Online version, Pain Chapter, proton pump inhibitors are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of non-steroidal anti-inflammatory drug use. Risk factors for gastrointestinal events include age greater than 65 years; history of peptic ulcer, gastrointestinal (GI) bleeding or perforation; concurrent use of aspirin (ASA), corticosteroids, and/or an

anticoagulant; or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). There is no indication that the injured worker is at risk for gastrointestinal events requiring the use of proton pump inhibitors. Furthermore, long-term PPI use (greater than 1 year) has been shown to increase the risk of hip fracture. As such, the request for Lansoprazole 30mg cannot be established as medically necessary.