

<b>Case Number:</b>	CM14-0023875		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	11/22/2012
<b>Decision Date:</b>	07/15/2014	<b>UR Denial Date:</b>	02/21/2014
<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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 59-year-old female who reported an injury on 11/22/2012 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to her right knee, low back, and right shoulder. The injured worker's treatment history included surgical intervention to the shoulder, postoperative physical therapy, and an H-Wave unit. The injured worker was prescribed multiple medications for symptom relief. The injured worker was evaluated on 02/12/2014. It was documented that the injured worker had decreased pain of the right shoulder status post a corticosteroid injection. Physical findings included limited right shoulder range of motion secondary to pain and limited right knee range of motion secondary to pain. The injured worker's medications were noted to be Medrox pain patch and Tylenol extended release capsules. The injured worker's diagnoses included status post right shoulder arthroscopic rotator cuff repair, severe postoperative stiffness, cervical degenerative spine disease, right carpal tunnel syndrome, right medial meniscus tear, and postoperative rotator cuff tear. The injured worker's treatment plan included continued physical therapy with consideration of manipulation under anesthesia and continuation of medications as prescribed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**OMEPRAZOLE 20 MG:** Upheld

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

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

**Decision rationale:** The requested omeprazole 20 mg is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends this type of medication for injured workers who are at risk for developing gastrointestinal related symptoms secondary to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's gastrointestinal system to support that they are at risk for developing gastrointestinal related symptoms secondary to medication usage. Additionally, the requested as it is submitted does not provide a quantity for frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested omeprazole 20 mg is not medically necessary or appropriate.

**NORCO (UNSPECIFIED DOSAGE/QUANTITY):** Upheld

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

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

**Decision rationale:** The requested Norco (unspecified quantity and dosage) is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, assessment of pain relief, major side effect, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review fails to provide any evidence of functional benefit or pain relief resulting from the use of this medication. Additionally, there is no documentation that the injured worker is monitored for aberrant behavior. Furthermore, the request as it is submitted did not specify a quantity, dosage, or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Norco unspecified dosage and quantity are not medically necessary or appropriate.

**TYLENOL (UNSPECIFIED DOSAGE/QUANTITY):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen Page(s): 11.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Page(s): 60.

**Decision rationale:** The requested Tylenol (unspecified dosage and quantity) is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the

injured worker has been on this medication for an extended duration of time. The California Medical Treatment Utilization Schedule recommends that any medication used in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. The clinical documentation fails to provide any evidence that the injured worker has any pain relief or functional benefit resulting from the use of the medication. Furthermore, the request as it is submitted does not specifically identify a dosage frequency or quantity. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Tylenol (unspecified dosage and quantity) is not medically necessary or appropriate.

**PROZAC (UNSPECIFIED DOSAGE/QUANTITY): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Use Page(s): 16.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 287-388.

**Decision rationale:** The requested Prozac (unspecified dosage and quantity) is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does recommend a short course of antidepressants for injured workers who have depressive symptoms related to chronic pain. The clinical documentation does not provide a treatment history of the use of the medication. Therefore, the appropriateness of continued use cannot be determined. Additionally, the request as it is submitted does not specifically identify a frequency, dosage, or quantity. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Prozac (unspecified dosage and quantity) is not medically necessary or appropriate.