

<b>Case Number:</b>	CM14-0035079		
<b>Date Assigned:</b>	06/23/2014	<b>Date of Injury:</b>	02/22/2010
<b>Decision Date:</b>	08/18/2014	<b>UR Denial Date:</b>	03/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/21/2014

### 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 54 year old male who was injured on 02/22/2010. The mechanism of injury is unknown. Prior treatment history has included back brace, hot and cold wrap, home exercise program, chiropractic therapy and TENS unit. Ortho evaluation dated 03/07/2014 states the patient complained of persistent right and left shoulder pain, worse on the left side; and persistent neck pain and low back pain. On exam, the patient has tenderness along the cervical and lumbar paraspinals bilateral and right shoulder. He has pain along the rotator cuff and biceps tendon. Abduction is 90 degrees with weakness to resisted function, 4+/5, with external rotation, internal rotation and abduction. He has a positive Hawkins ands speet test. Positive O'Brien test. Diagnoses are discogenic lumbar condition, impingement syndrome of the shoulder on the right; depression and sleep; and compressive left shoulder strain for which there has been no treatment. The patient has been recommended Tramadol ER, Gabapentin (Neurontin), Norco, LidoPro cream, Terocin patches, Naproxen and Protonix (dosages are provided below). There are no measurable findings to indicate the efficacy of these medications. Prior utilization review dated 03/11/2014 states the request for Norco 10/325 mg #150, Neurontin 600mg #90 is denied as it is not medically necessary; Tramadol ER 150mg #30 is denied as it is not medically necessary but has been modified to Tramadol ER 150 mg #15 as the purpose of weaning is medically necessary; LidoPro cream one bottle is not certified as guideline criteria has not been met; Terocin patches 30 is denied as it is not medically necessary; Naproxen 550mg #60 and Protonix 20mg #60 are not certified as guideline criteria has not been met.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 #150:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids  
Page(s): 74-96.

**Decision rationale:** According to MTUS guidelines opioids are recommended for chronic pain if efficacy is established though studies have generally failed to demonstrate improved outcomes in terms of pain, function, or quality of life from long-term opioid use. In this case the patient is taking Norco on a chronic basis for pain. However, medical records fail to demonstrate objective clinically significant functional improvement or reduction in dependency on medical care due to opioid use. The patient is not working and continues to complain of significant pain and dysfunction. Medical necessity is not established.

**Neurontin 600mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 16-22.

**Decision rationale:** According to MTUS guidelines, Gabapentin has been considered first-line treatment for neuropathic pain. However, neuropathic pain is not clearly established in this patient by history, examination, or diagnostics. Medical records do not demonstrate clinically significant functional improvement or reduction in dependency on medical care due to use of Gabapentin. Medical necessity is not established.

**Tramadol ER 150mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids  
Page(s): 74-96.

**Decision rationale:** According to MTUS guidelines, Tramadol may be indicated for moderate to severe pain though long-term is not recommended due to lack of proven efficacy. In this case the patient is taking Tramadol on a chronic basis without demonstrated clinically significant functional improvement. Medical necessity is not established.

**LidoPro cream one bottle:** 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): 111-113.

**Decision rationale:** According to MTUS guidelines, topical Lidocaine may be indicated for localized, peripheral neuropathic pain after a failure of oral anticonvulsants. The only recommended formulation is the Lidoderm patch. In this case the patient does not clearly have neuropathic pain nor is the requested formulation a recommended product. Medical necessity is not established.

**Terocin patches 30:** 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): 111-113.

**Decision rationale:** According to MTUS guidelines, topical Lidocaine may be indicated for localized, peripheral neuropathic pain after a failure of oral anticonvulsants. The only recommended formulation is the Lidoderm patch. Terocin patch appear to be a formulation of Lidocaine and Menthol. In this case the patient does not clearly have neuropathic pain nor is the requested formulation a recommended product. Medical necessity is not established.

**Naproxen 550mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-73.

**Decision rationale:** According to MTUS guidelines, NSAIDs are recommended at the lowest dose for the shortest duration possible for osteoarthritis. They are recommended as a second-line option after acetaminophen for acute exacerbations of chronic low back pain. In this the patient appears to be prescribed Naproxen on a chronic basis, yet clinically significant functional benefit is not evident from review of the provided medical records. Medical necessity is not established.

**Protonix 20mg #60:** 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 Guidelines, NSAIDs, GI Symptoms, and Cardiovascular Risk Page(s): 68-69.

**Decision rationale:** According to MTUS guidelines, PPI's, such as Protonix, may be indicated for patient taking NSAIDs at moderate to high risk of gastrointestinal events. However, in this case the patient is taking Naproxen on a chronic basis, which does not appear to be medically necessary. Further, moderate to high risk of gastrointestinal events is not documented. Medical necessity is not established.