

<b>Case Number:</b>	CM14-0086940		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	10/10/2012
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	05/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2014

### 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 and Rehabilitation 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 injured worker is 49 year old female who reported an injury on 10/10/2012; the mechanism of injury was not indicated. The injured worker had diagnoses including right shoulder impingement syndrome and gastric secondary to non-steroidal anti-inflammatory drugs. Prior treatment included injections to the right elbow in 2013, physical therapy 18 visits, and chiropractic treatment for 6 visits. Diagnostic studies included an MRI of the upper extremity on 02/19/2013 and an x-ray of the right elbow on 10/15/2013. The injured worker underwent arthroscopy of the right shoulder on 06/17/2013. The injured worker complained of severe right shoulder pain. The clinical note dated 05/13/2014 revealed restricted range motion in the right shoulder and deltoids atrophy. Examination of the left shoulder was normal. The injured worker was getting better with physical therapy. Medications included prilosec, celebrex, and ultram. A urine drug screen was performed on 02/11/2014 which was positive for Tramadol which was consistent with the injured worker's prescribed medication regimen. The treatment plan included a request for Ultram ER 150 mg quantity 60, Celebrex 200 mg quantity 30 and Norco 2.5 mg quantity 90. The rationale for the request was to lessen his pain and improve his function particularly range of motion of right the shoulder. The request for authorization was not provided within the medical records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultram ER 150 mg # 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Opioids Page(s): 76-80,.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113.

**Decision rationale:** The request for Ultram ER 150 mg #60 is not medically necessary. The California MTUS guidelines recommend continuing review with documentation of pain relief, functional status, appropriate medication use, and side effects. The patient pain assessment should include, current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment must be indicated by the patient's decreased pain, increased level of function, or improved quality of life. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The requesting physician did not provide documentation of an adequate and complete assessment of the injured worker's pain. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore, the request is not medically necessary.

**Celebrex 200 mg # 30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) & Anti-inflammatory medications Page(s): 67-68, 2.

**Decision rationale:** The request for Celebrex 200 mg #30 is not medically necessary. The injured worker complained of severe right shoulder pain. The California MTUS guidelines recommend the use of NSAIDs for patients with osteoarthritis (including knee and hip) and patients with acute exacerbations of chronic low back pain. The guidelines recommended NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. In patients with acute exacerbations of chronic low back pain, the guidelines recommend NSAIDs as an option for short-term symptomatic relief. The guidelines also note, COX-2 inhibitors (e.g., Celebrex) may be considered if the patient has a risk of GI complications, but not for the majority of patients. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. There is a lack of documentation demonstrating the injured worker has significant gastrointestinal symptoms for which a gastrointestinal protectant would be indicated. Additionally, the request failed to provide the frequency of symptoms to support Celebrex to be utilized. Therefore, the request is not medically necessary.

**Norco 2.5 mg # 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 76-80, 91, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

**Decision rationale:** The request for Norco 2.5 mg #90 is not medically necessary. The California MTUS guidelines recommend continuing review with documentation of pain relief, functional status, appropriate medication use, and side effects. The patient pain assessment should include, current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment must be indicated by the patient's decreased pain, increased level of function, or improved quality of life. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The requesting physician did not provide documentation of an adequate and complete assessment of the injured worker's pain. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore, the request is not medically necessary.