

<b>Case Number:</b>	CM15-0185763		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	07/25/2012
<b>Decision Date:</b>	12/24/2015	<b>UR Denial Date:</b>	09/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 57 year old male, who sustained an industrial-work injury on 7-25-12. A review of the medical records indicates that the injured worker is undergoing treatment for pain in joint of the left shoulder. Medical records dated 9-2-15 indicate that the injured worker complains of bilateral shoulder pain and had an evaluation for Functional Restoration Program. Per the treating physician report dated 9-2-15 the work status is with restrictions. The physical exam dated 9-2-15 reveals right upper extremity has atrophy and arm abduction is 3 out of 5. The left upper extremity arm abduction is 4 out of 5. He denies any constipation or heartburn. The physician indicates that the medications help with pain sand function and allow him to tolerate repetitive movements of bilateral shoulders and lifting. The injured worker reports that the capsaicin cream is very helpful when the pain is more severe so he can avoid taking the strong pain medications and it helps to take the edge off his pain. Treatment to date has included pain medication Diclofenac, Hydrocodone-Acetaminophen, Gabapentin, Ibuprofen, Capsaicin 0.025% cream, Cyclobenzaprine, Flexeril, Pantoprazole, Protonix, and Venlafaxine since at least 4-29-15, left shoulder surgery 11-26-12, physical therapy, acupuncture, and other modalities. The request for authorization date was 9-8-15 and requested services included Capsaicin 0.025% cream #60, Cyclobenzaprine, Flexeril 7.5 mg #90, Pantoprazole, Protonix 20 mg #60, and Venlafaxine HCL ER 37.5 mg #120. The original Utilization review dated 9-11-15 non-certified the request for Capsaicin 0.025% cream #60, Cyclobenzaprine, Flexeril 7.5 mg #90, Pantoprazole, Protonix 20 mg #60, and Venlafaxine HCL ER 37.5 mg #120.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Capsaicin 0.025% cream #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Capsaicin, topical.

**Decision rationale:** Regarding request for capsaicin cream, guidelines state that it is recommended only as an option for patients who did not respond to, or are intolerant to other treatments. Within the documentation available for review, there is no indication that the patient has obtained any objective functional improvement from the use of capsaicin cream. Additionally, there is no indication that the patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin therapy. In the absence of clarity regarding those issues, the currently requested capsaicin cream is not medically necessary.

**Cyclobenzaprine, flexeril 7.5 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** Regarding the request for cyclobenzaprine, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Given this, the current request is not medically necessary.

**Pantoprazole, Protonix 20 mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, PPI.

**Decision rationale:** Regarding the request for pantoprazole (Protonix), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Additionally, ODG recommends Nexium, Protonix, Dexilant, and AcipHex for use as 2nd line agents, after failure of omeprazole or lansoprazole. Within the documentation available for review, there is no indication that the patient has failed first-line agents prior to initiating treatment with pantoprazole (a 2nd line proton pump inhibitor). In the absence of clarity regarding those issues, the currently requested pantoprazole is not medically necessary.

**Venlafaxine HCL ER 37.5 mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain.

**Decision rationale:** Regarding the request for venlafaxine (Effexor), guidelines state that antidepressants are recommended as a 1st line option for neuropathic pain and as a possibility for non-neuropathic pain. Guidelines go on to recommend a trial of at least 4 weeks. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Within the documentation available for review, the provider stated the medication is prescribed for both neuropathic pain and depression. There is documentation that Effexor is helping with depression. However, there is no identification that the Effexor provides any specific analgesic effect (in terms of reduced numeric rating scale or percent reduction in pain), or provides any objective functional improvement. Given this, this request is not medically necessary.