

<b>Case Number:</b>	CM15-0190878		
<b>Date Assigned:</b>	10/05/2015	<b>Date of Injury:</b>	02/16/2010
<b>Decision Date:</b>	11/12/2015	<b>UR Denial Date:</b>	09/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/28/2015

### 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: Connecticut, California, Virginia  
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 51 year old female, who sustained an industrial injury on 2-16-2010. Medical records indicate the worker is undergoing treatment for status post rotator cuff and biceps tendon repair and cervical degenerative disc disease. A recent progress report dated 8-18-2015, reported the injured worker complained of left shoulder pain but noted improvement since last visit. She rated her pain at 7 out of 10 and reports the pain is worse by joint range of motion and alleviated by Norco, NSAID (non-steroidal anti-inflammatory drug) and Omeprazole Physical examination revealed left shoulder 180 degrees passive elevation and 150 degrees active elevation with pain. Treatment to date has included surgery, physical therapy, Norco (since at least 3-26-2015) and Voltaren gel. On 8-31-2015, the Request for Authorization is requesting Norco 10-325mg #50 and Voltaren gel 1%-30 day supply. On 9-8-2015, the Utilization Review noncertified the request for Norco 10-325mg #50 and Voltaren gel 1%-30 day supply.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg quantity 50: 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): Opioids, criteria for use, Opioids for chronic pain, Opioids, dosing, Opioids, long-term assessment, Opioids, specific drug list.

**Decision rationale:** Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain in this patient since the initial date of injury, consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate. Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case, the patient clearly warrants close monitoring and treatment, to include close follow up regarding improvement in pain/function; consideration of additional expertise in pain management should be considered if there is no evidence of improvement in the long term. More detailed consideration of long-term treatment goals for pain (specifically aimed at decreased need for opioids), and further elaboration on dosing expectations in this case would be valuable. Consideration of other pain treatment modalities and adjuvants is also recommended. Utilization Review reasonably non-certified the request and recommended appropriate weaning. Given the lack of clear evidence to support functional improvement on the medication and the chronic risk of continued treatment, the request for Norco is not considered medically necessary.

**Voltaren gel 1%, 30 day supply:** 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): Topical Analgesics.

**Decision rationale:** The MTUS lists diclofenac sodium gel as an FDA approved medication indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip, or shoulder. The provided documents do not provide strong objective evidence of functional improvement. Continued use of topical diclofenac is not indicated without further substantiation, and therefore the request cannot be considered medically necessary.