

<b>Case Number:</b>	CM15-0200531		
<b>Date Assigned:</b>	10/15/2015	<b>Date of Injury:</b>	12/20/1996
<b>Decision Date:</b>	11/25/2015	<b>UR Denial Date:</b>	09/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/13/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 58 year old male, who sustained an industrial injury on 12-20-1996. The injured worker was being treated for a history of complex regional pain syndrome of right upper extremity, history of gastritis, depression, status post right lateral epicondylectomy with persistent lateral epicondylitis, status post right lateral epicondyle PRP 11-2014, right shoulder impingement with adhesive capsulitis, right median neuropathy, and chronic C7 radiculopathy. Treatment to date has included diagnostics, right lateral epicondyle surgery in 1998, "therapy", and medications. Per the most recent progress report (7-21-2015), the injured worker complains of "modest" pain involving his arms and restricted motion of the right shoulder, along with painful use. Pain was not numerically rated on 7-21-2015 or 5-12-2015. Medications included Percocet, Lyrica, Lisinopril, Metoprolol, Cymbalta, Nexium, and "pain patches". A review of symptoms was negative for gastrointestinal complaints. Exam noted an elevated blood pressure, "significant" tenderness about the right shoulder, "moderate" tenderness over the lateral epicondyle, additional tenderness over the right cubital tunnel, and "some distal tenderness" over the palmar wrist surface. Sensation was decreased in the index, middle, and ring fingers of the right hand, along with positive Tinel, Durkin and Phalen signs. Right shoulder active range of motion was "quite limited" with less than 90 degrees of abduction or forward flexion; however nearly full passive range of motion was obtainable with grimace. Cervical range of motion was "moderately" attenuated with Spurling sign creating dysesthesias into the right axilla. It was documented that he continued to have issues with diabetes and was briefly hospitalized for a possible stroke a few weeks prior, noting that the "current use of medication has been extremely

helpful in regards to obtaining better restful sleep and engaging in more activities during the day despite the shoulder pain". Function with activities of daily living was not described. He was dispensed Ultracet, Effexor XR, and Protonix. Progress reports note the use of Ultracet since at least 11-06-2014, along with the use of Nexium for a history of chronic gastritis, secondary to medications. A gastrointestinal consult report (2-13-2015) was documented to recommend the use of proton pump inhibitor. The progress report (11-25-2014) noted "the drug screen previously performed is entirely consistent", date unspecified. Urine toxicology was documented as performed 1-27-2015, not commented on visit 3-03-2015, report not submitted. The treatment plan included Ultracet 37.5-325mg #60 four times daily (dispensed 8-17-2015) and Protonix 20mg #120 with 2 tabs twice daily (dispensed 8-17-2015), non-certified by Utilization Review on 9-17-2015.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Retro Ultracet 37.5/325 mg #60 with a DOS of 8/17/2015: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**Decision rationale:** The California MTUS states: When to Continue Opioids: (a) If the patient has returned to work; (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function or activity specifically due to the medication. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.

**Retro Protonix 20 mg #120 with a DOS of 8/17/2015: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** The California chronic pain medical treatment guidelines section on NSAID therapy and proton pump inhibitors (PPI) states: Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids,

and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDs to develop gastro duodenal lesions. Recommendations Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.). Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 ug four times daily); or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. There is no documentation provided that places this patient at intermediate or high risk that would justify the use of a PPI. There is no mention of current gastrointestinal or cardiovascular disease. For these reasons the criteria set forth above per the California MTUS for the use of this medication has not been met. Therefore the request is not medically necessary.