

<b>Case Number:</b>	CM15-0058924		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	06/26/2007
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	03/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2015

### 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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 63-year-old male who reported injury on 06/25/2007. The mechanism of injury was lifting. The injured worker underwent a right rotator cuff repair and a shoulder decompression consisting of a resection of the distal clavicle and coracoacromial ligament, acromioplasty and repair rotator cuff on 01/31/2008. Prior treatments included medications, physical therapy, and a TENS unit. The injured worker was noted to undergo urine drug screens. The documentation of 02/25/2015 revealed the injured worker was taking medications and checked himself regularly due to diabetes. The injured worker was utilizing a hot and cold wrap and a 2 leads TENS unit. The documentation indicated the injured worker would like a stronger machine. The injured worker could not lift more than 8 pounds on the right and 16 pounds on the left. The objective findings revealed limited range of motion of the shoulder and tenderness along the biceps tendon, AC joint and rotator cuff with weakness to resisted function. The diagnoses included rotator cuff tear on the right status post decompression, rotator cuff repair and distal clavicle excision with persistent AC joint inflammation and bicipital tendinitis and stiffness. The treatment plan included tramadol ER 150 mg #30, Flexeril 700 mg, LidoPro cream 1 bottle, Nalfon 60 mg and Protonix 20 mg with the addition of a 4 lead TENS unit with garment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

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

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement, an objective decrease in pain and documentation the injured worker was being monitored for aberrant drug behavior. Additionally, there was a lack of documentation indicating the injured worker was being monitored for side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for tramadol ER 150 mg #30 is not medically necessary.

**Flexeril 5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41, 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** The California MTUS guidelines recommend muscle relaxants as a second line option for the short-term treatment of acute low back pain, less than 3 weeks and there should be documentation of objective functional improvement. The clinical documentation submitted for review failed to indicate the injured worker had muscle spasms upon examination. There was a lack of documentation of exceptional factors. There was a lack of documentation indicating a necessity for 60 tablets, as this treatment is not recommended for greater than 3 weeks. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Flexeril 5 mg #60 is not medically necessary.

**Nalfon 400mg #60:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines indicate that NSAIDS are recommended for short term symptomatic relief of mild to moderate pain. There should be documentation of

objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker had previously utilized NSAIDS and failed their usage. However, there was a lack of documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Nalfon 400 mg #60 is not medically necessary.

**Protonix 20mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

**Decision rationale:** The California MTUS guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events and are also for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to provide a rationale for the requested medication. There was a lack of documentation indicating the injured worker was at intermediate or higher level risk for gastritis. Additionally, there was a lack of documentation of signs and symptoms of dyspepsia. The request as submitted failed to indicate the request for the requested medication. Additionally, the NSAID was found to be not medically necessary, as such, this medication would not be medically necessary. Given the above, the request for Protonix 20 mg #60 is not medically necessary.

**Lidopro cream bottle: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals, Topical Analgesic, Topical Capsaicin, Lidocaine Page(s): 105, 111, 28, 112. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/search.php?searchterm=LidoPro>.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or

an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. Per drugs.com, LidoPro is a topical analgesic containing capsaicin / lidocaine / menthol / methyl salicylate. The clinical documentation submitted for review failed to provide documentation of a trial and failure of antidepressants and anticonvulsants. The efficacy was not provided. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. The request as submitted failed to indicate the frequency and the body part to be treated. Given the above and the lack of documentation of exceptional factors, the request for LidoPro cream bottle is not medically necessary.

**4 lead TENS unit with conductive garment:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114-116.

**Decision rationale:** The California MTUS Guidelines indicate a form fitting device is appropriate if there is documentation that there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment or the injured worker has a medical condition that prevents the use of a traditional system. The clinical documentation submitted for review indicated the injured worker was requesting a stronger coverage. However, there was a lack of documentation indicating there was such a large area that required stimulation that a conventional system could not accommodate treatment and that the injured worker had medical conditions that prevented the use of a traditional system. Additionally, the guidelines indicate that if a 4 lead unit is recommended, there must be documentation of why this is necessary. The clinical documentation indicated the injured worker requested a stronger unit. However, the objective functional benefit was not provided. There was a lack of documentation of the injured worker's pain on a VAS to support a need for a 4 lead. There was a lack of documented rationale for the 4 lead. Given the above, the request for 4 lead TENS unit with conductive garment is not medically necessary.