

<b>Case Number:</b>	CM14-0090838		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	10/31/2011
<b>Decision Date:</b>	09/03/2014	<b>UR Denial Date:</b>	05/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2014

### 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 Texas and Oklahoma. 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 a 51-year-old female who reported an injury on 11/18/2010, when she had a cumulative trauma from assembling microscopes. Diagnoses were status post right ulnar transposition surgery, right shoulder impingement/bursitis, right shoulder supraspinatus and infraspinatus tendinosis, status post right carpal tunnel release, and right elbow medial epicondylitis. Past treatments were surgeries, 24 sessions of physical therapy, 7 visits of physiotherapy, and 13 sessions of acupuncture. Diagnostics were MRI of the shoulder, MRI of the elbow, and MRI of the wrist. Surgical history was right carpal tunnel release and right ulnar transposition surgery. Physical examination on 07/16/2014 revealed complaints of pain in the right shoulder, right elbow, and right wrist. The injured worker stated her pain was at a 5/10, she described her pain as a localized numbness and tingling. She rated the pain for her right elbow as a 2/10. The injured worker rated her wrist pain at a 6/10 to 7/10. Examination of the right shoulder revealed no swelling, deformity, or effusion. Range of motion for the right shoulder revealed flexion was to 170 degrees, extension was to 60 degrees, abduction was to 170 degrees, external rotation to the side was to 45 degrees, internal rotation was to 60 degrees. There was no tenderness to palpation on the ligament, tendon, or bone structures. There was no pain reported with range of motion. Neuro examination revealed strength was a 4+/5 internal and external rotators, biceps, deltoids. Sensation was normal to radial, median, ulnar, and auxiliary nerves. Physical examination of the right wrist and hand revealed no swelling, deformity, or effusion. Medications were Norco 5/325, 3 tablets daily; Elavil 10 mg, 1 tablet at night; Prilosec; and LidoPro, 3 tablets daily. Treatment plan was for a right shoulder steroid injection and to continue medications as directed. The rationale and Request for Authorization were not submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Amitriptyline HCL 10 mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Specific antidepressants Page(s): 15.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Amitriptyline Page(s): 13.

**Decision rationale:** The requested is not medically necessary. Per California Medical Treatment Utilization Schedule (MTUS) Guidelines, recommends Amitriptyline. Amitriptyline is a tricyclic antidepressant. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. The documents submitted for review lacked indication the injured worker being depressed. In addition the request that was submitted lacked frequency and duration. As such the request for Amitriptyline HCL 10 mg is not medically necessary.

**Hydrocodone/APAP 5/325 mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80, 91, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going Management Page(s): 78.

**Decision rationale:** The request for Hydrocodone/ACAP 5/325 mg, #60 is not medically necessary. The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There was no urine drug screen indicating opioids compliance. The provider failed to indicate long-term functional goals. In addition, the request did not indicate a frequency of medication. Therefore, the request is not medically necessary.

**LidoPro topical ointment 4 ounces:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 105, 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** The request for LidoPro topical ointment is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also state that any compounded product contains at least one

drug (or drug class) that is not recommended. The guidelines state that there are no other commercially approved topical formulation of Lidocaine (whether creams, lotions, or gels) that are indicated for neuropathic pain other than Lidoderm. The proposed gel contains methyl salicylate and menthol. In addition, there was no documentation provided on frequency or location where the LidoPro topical ointment on would be applied was not provided. As such, the request for LidoPro topical ointment is not medically necessary.

**Omeprazole 20 mg capsules #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Proton pump inhibitors Page(s): 68-69.

**Decision rationale:** The request is not medically necessary. Prilosec is recommended for patients taking NSAIDs who are at risk of gastrointestinal events. The documentation submitted did indicate the injured worker having gastrointestinal events. However, provider failed to indicate the frequency and quantity medication on the request that was submitted. In addition, the provider failed to indicate long term functional goals or medication pain management outcome measurements for the injured worker. Given the above, the request for Omeprazole 60 mg capsules #60 is not medically necessary.