

<b>Case Number:</b>	CM15-0013498		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	01/07/2011
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	01/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/23/2015

### 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: Texas, New York, California  
 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 49 year old male, who sustained an industrial injury on 01/07/2011. He has reported right shoulder and right hand pain. The diagnoses have included right shoulder impingement syndrome with tendinitis/bursitis; right shoulder partial thickness rotator cuff tear; right shoulder bicipital tenosynovitis; and right thumb carpometacarpal arthritis. Treatment to date has included medications, cortisone injection, physical therapy, and activity modification. Medications have included Ultram, Anaprox, and Flurbiprofen 25% topical cream. A progress note from the treating physician, dated 11/26/2014, documented a follow-up visit with the injured worker. The injured worker reported ongoing right shoulder and right hand pain. Objective findings included tenderness to palpation over the lateral deltoid, biceps tendon, acromioclavicular joint, and anterior and lateral acromion on the right; tenderness to palpation over the right first carpometacarpal joint; and decreased range of motion of the right shoulder. The treatment plan includes proceeding with right shoulder arthroscopy pending authorization; continuation/prescriptions of medications; and follow-up evaluation as scheduled. On 01/12/2015 Utilization Review noncertified a prescription for Anaprox 550 mg #60 No NDC #, No Refills, NSAID; modified a prescription for Ultram 150 mg #30, No NDC #, No Refills, Central Acting Analgesic, to Ultram 150 mg #15; and noncertified a prescription for Flurbiprofen 25 Percent Lipoderm Base, No NDC #, No Refills, CMPD-Topical Analgesic. The CA MTUS and the ODG were cited. On 01/23/2015, the injured worker submitted an application for IMR for review of a prescription for Anaprox 550 mg #60 No NDC #, No Refills, NSAID; a prescription for Ultram 150 mg #30, No NDC #, No Refills, Central Acting Analgesic; and a

prescription for Flurbiprofen 25 Percent Lipoderm Base, No NDC #, No Refills, CMPD-Topical Analgesic.

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

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

**Anaprox 550 MG #60 No NDC #, No Refills NSAID:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management Page(s): Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20; 9792.26 MTUS (Effective July 18, 2009) Page 7 of 127.

**Decision rationale:** No, the request for Anaprox (Naprosyn), an anti-inflammatory medication, was not medically necessary, medically appropriate, or indicated here. As noted on page 7 of the MTUS Chronic Pain Medical Treatment Guidelines, attending provider should incorporate some discussion of medication efficacy into its choice of recommendations. Here, however, the attending provider was/is off of work, on total temporary disability, despite ongoing usage of Naprosyn. The applicant continued to report pain complaints as high as 8 to 9/10 as of October 15, 2014, again, despite ongoing usage of Naprosyn. Ongoing usage of Naprosyn failed to curtail the applicant's dependence on opioid agents such as tramadol. Multiple progress notes, referenced above, in late 2014, contained little-to-no discussion of medications efficacy. All of the foregoing, taken together, suggests a lack of functional improvement as defined in MTUS 9792.20f, despite ongoing use of Naprosyn. Therefore, the request was not medically necessary.

**Ultram 150 MG #30, No NDC #, No Refills, Central Acting Analgesic:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 7) When to Continue Opioids Page(s): Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20; 9792.26 MTUS (Effective July 18, 2009) Page 80 of 127.

**Decision rationale:** Similarly, the request for Ultram, a synthetic opioid, was likewise not medically necessary, medically appropriate, or indicated here. As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved functioning, and/or reduced pain achieved as a result of the same. Here, however, the applicant was off of work, on total temporary disability. The applicant continued to report pain complaints as high as 8 to 9/10, despite ongoing Ultram (tramadol) usage. The attending provider failed to outline any meaningful or material improvements in function affected as a result of ongoing tramadol usage. Therefore, the request was not medically necessary.

**Flurbiprofen 25 Percent Lipoderm Base, No NDC #, No Refills, CMPD-Topical Analgesic:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20; 9792.26 MTUS (Effective July 18, 2009) Page 112 of 127 Page(s): Non-steroidal antiinflammatory agents (NSAIDs).

**Decision rationale:** Finally, the request for flurbiprofen containing topical compound was likewise not medically necessary, medically appropriate, or indicated here. While page 112 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that topical NSAIDs are recommended in the treatment of small joint arthritis and/or tendonitis in regions and/or joints which are amenable to topical applications, in this case, however, the applicant has had several pain generators, including the hand, forearm, wrist, shoulder, etc. The applicant's pain complaints, thus, were likewise too widespread to be amenable to topical application. Therefore, the request was not medically necessary.