

<b>Case Number:</b>	CM15-0013565		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	09/17/2013
<b>Decision Date:</b>	03/26/2015	<b>UR Denial Date:</b>	12/26/2014
<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: New York, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency 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 67 year old male, who sustained an industrial injury on September 17, 2013. The diagnoses have included right shoulder impingement syndrome with rupture of the long head of the biceps and supraspinatus tendons, status post right shoulder arthroscopy procedure and subacromial decommission on September 10, 2014. Treatment to date has included right shoulder arthroscopy procedure and subacromial decommission on September 10, 2014 and oral medications. Currently, the injured worker complains of right shoulder. In a progress note dated November 10, 2014, the treating provider reports the injured worker continues to improve in regards to strength and range of motion with decreasing pain, following right shoulder surgery on September 10, 2014, there is minimal swelling about the shoulder with a marked decrease in the degree of preoperative tenderness, full active range of motion is restored and distal sensory motor function is intact. On December 26, 2014 Utilization Review non-certified a retro Protonix 20mg quantity 60, retro Ultram ER 150mg quantity 60, and retro Voltaren 100mg quantity 60, noting, MTUs was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETRO Protonix 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 67-68, 71.

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

**Decision rationale:** Protonix is recommended for patients at risk for GI events. Factors include: age over 85 years, history of peptic ulcer, gi bleeding or perforation, concurrent use of aspirin, corticosteroids or an anticoagulant, or high dose NSAIDs. Furthermore long term PPI use over one year has been shown to increase risk of hip fracture. In this case, the patient is not at risk for GI events, and has not failed first-line agents such as omeprazole and lansoprazole and thus the request is not medically appropriate and necessary.

**RETRO Ultram ER 15mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Specific Drug List, Tramadol (Ultram) Page(s): 93-94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

**Decision rationale:** Ultram is indicated for moderate to moderately severe pain and is not indicated for long term use. Monitoring of opioid use includes noting the degree of pain relief, occurrence of side effects, functional improvement, and abusive potential. In this case, the patient has been on opiates long term. However the medical records do not adequately document degree of pain relief, functional improvement, or lack of adverse side effects as required by MTUS guidelines. Thus this medication was not medically appropriate and necessary.

**RETRO Voltaren 100mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal Anti-Inflammatory Drugs (NSAIDs), Osteoarthritis (in.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-68.

**Decision rationale:** NSAIDs such as Voltaren are recommended as an option for short term pain relief as they have potential adverse effects on the GI tract and cardiovascular systems. NSAIDs have also been shown to delay healing in muscles and ligaments and other soft tissues. Guidelines recommend the lowest effective dose be used for NSAIDs for the shortest duration possible. In this case, the patient has been on long term NSAIDs without any documentation of significant benefit through prior use. Thus prolonged use of Voltaren as requested is not medically appropriate and necessary.