

<b>Case Number:</b>	CM15-0173237		
<b>Date Assigned:</b>	09/16/2015	<b>Date of Injury:</b>	05/09/2012
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	08/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/02/2015

### 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  
 Certification(s)/Specialty: Internal 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 56 year old female who sustained an industrial injury on 5-9-12. A review of the medical records indicates she is undergoing treatment for right shoulder impingement, bicipital tendinitis, and rotator cuff strain. Medical records (4-14-15 to 8-11-15) indicate ongoing complaints of right shoulder pain and pain from the neck to the thumb and first finger with numbness and tingling. On 8-11-15, her shoulder pain was noted to be "intermittent". The physical exam reveals tenderness along the right shoulder, rotator cuff and biceps tendon. The report states "abduction is 125 degrees with discomfort". Diagnostic studies have included an MRI of the right shoulder. Treatment has included hot and cold wraps, a TENS unit, and medications. The medications have included Naproxen 550mg, Protonix 20mg, Tramadol ER 150mg, and Norco 10mg. The treatment recommendations on 8-11-15 included the previously ordered medications, as well as Voltaren gel 1% 100gms, three tubes. The utilization review (8-21-15) indicates requests for authorization of Naproxen 550mg, #60, Protonix 20mg, #60, Tramadol ER 150mg, #30, Norco 10-325, #60, and Voltaren gel 1%, 3 tubes. The determination denied all medications, indicating as follows: Naproxen - citing documentation "lacks efficacy" of the medication; Protonix - due to denial of Naproxen; Tramadol ER and Norco - "no objective evidence of functional benefit obtained from opioid medication"; and Voltaren gel - cites that "topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In this case the submitted documentation does not reflect the failure of first line of medication treatment such as antidepressant and anticonvulsant medications".

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Naproxen 550 MG Qty 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines for non-steroidal anti-inflammatory drugs recommend use for acute conditions or for acute exacerbation of conditions for short term therapy. It is recommended at lowest dose for the shortest period in patient with moderate to severe pain. Specific recommendations include osteoarthritis, back pain, and may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis with neuropathic pain. "Functional improvement" is evidenced by a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management. Medical record did not include evidence of functional improvement with this medication and reduction in the dependency on continued medical treatment. There was no evidence of an acute condition or an acute exacerbation of the condition that determined the medical necessity of the medication. Therefore Naproxen 550 MG Qty 60 is not medically necessary and appropriate.

**Protonix 20 MG Qty 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** According to the California MTUS (2009), Protonix, is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented GI distress symptoms, or at risk for gastrointestinal events. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. Injured worker is on NSAIDs, there is no documentation of GI symptoms or any identifiable risk factors. The Requested Treatment: Protonix 20 MG Qty 60 is not medically necessary and appropriate.

**Tramadol ER 150 MG Qty 30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids for chronic pain.

**Decision rationale:** According to the California MTUS, Tramadol (Ultram) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. There is no compelling evidence presented by the treating provider that indicates this injured worker has had any significant improvements from this medication. Also review of Medical Records do not clarify that previous use of this medication has been effective in this injured worker for maintaining any functional improvement. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

**Norco 10/325 MG Qty 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids for chronic pain.

**Decision rationale:** The California MTUS chronic pain medical treatment guidelines recommend specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain. "Recommendations include the lowest possible dose be used as well as ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects. It is also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the use of the medication." The CA MTUS Guidelines define functional improvement as "a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management and a reduction in the dependency on continued medical treatment." Therapies should be focused on functional restoration rather than the elimination of pain. The medical records submitted for review does not include the above recommended documentation. There were no functional improvements noted with the use of the medication. There is no change on medical dependence. Therefore the requested treatment: Norco 10/325mg #60 is not medically necessary.

**Voltaren Gel 1 Percent 2 Tubes:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** According to the California MTUS Guidelines, Voltaren Gel 1% (Diclofenac) is indicated for the relief of osteoarthritis in joints that lend themselves to topical treatment, such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The submitted documentation does not indicate failure of antidepressants and anticonvulsants. There is also no documentation of intolerance to other previous oral medications. In addition, there was no dosage and frequency specified for the requested medication. Medical necessity for the requested topical gel has been not established. The requested treatment: Voltaren Gel 1 Percent 2 Tubes is not medically necessary.