

<b>Case Number:</b>	CM15-0062660		
<b>Date Assigned:</b>	04/08/2015	<b>Date of Injury:</b>	06/29/2007
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	03/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2015

### 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: California, Washington  
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 70-year-old female who reported injury on 06/29/2007. The mechanism of injury reportedly occurred as she was pulling shopping carts and felt a pull in her left shoulder. Her diagnoses included myalgia and chronic pain syndrome. Her past treatments have included medications, physical therapy, and work modifications. Diagnostic studies included an x-ray of the left shoulder performed on 01/09/2015, with findings of evidence of prior surgery, otherwise the left shoulder study is otherwise satisfactory. Pertinent diagnostics include an MR arthrogram of the left shoulder performed on 01/23/2009 with findings of evidence of tendon to bone repair with increased signal compatible with postsurgical changes and/or tendinosis. A focal area of undersurface tear of the most distal aspect of the supraspinatus tendon, which is new compared to the prior examination. Her surgical history includes a shoulder surgery. The injured worker presented on 03/05/2015 for a follow-up of her left shoulder pain. The injured worker indicated that she would like to try some therapy, as she still in pain. She reported muscles on both sides of neck and shoulder are tightened up and give her a headache. The clinical note indicated that the injured worker reported difficulty in sleeping without medication and the ability to function better with the use of medications. Upon physical examination, the injured worker had a negative Spurling's examination. The injured worker was positive for cervical tenderness. Physical examination of the left shoulder noted that the injured worker had restrictive range of motion, however pain was markedly better. The clinical note further indicated that an MRI performed in 2012 of the left shoulder indicated advanced glenohumeral. Her current medication regimen included Norco and tramadol. The treatment plan included consideration of a trial of Nucynta, a try of off label use of Hyalgan in the shoulder. The rationale for the request was that there were no addiction or intolerance issues noted, and the

clinician had a lot of good medical experience with Hyalgan in the shoulder. A Request for Authorization form dated 03/05/2015 was submitted for review. The injured worker is a 70 year old female, who sustained an industrial injury on June 29, 2007. She reported neck and bilateral shoulder pain with associated poor sleep and headaches. The injured worker was diagnosed as having chronic pain syndrome, failed shoulder surgery, advanced arthritis of the left and right shoulder, right shoulder sprain/strain, cervicgia and myofascial pain of the neck and shoulder girdle. Treatment to date has included radiographic imaging, diagnostic studies, surgical intervention of the shoulder, physical therapy, medications and work modifications. Currently, the injured worker complains of right elbow and left shoulder pain with swelling of the elbow noted. The injured worker reported an industrial injury in 2007, resulting in the above noted pain. She was treated conservatively and surgically without complete resolution of the pain. Evaluation on January 15, 2015, revealed continued pain in the shoulders, neck and elbows. Injections to the shoulders and medications were requested.

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

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

**Ultram ER (extended release) 50 mg Qty 180 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use On-Going Management Page(s): 76-78.

**Decision rationale:** The request for Ultram ER (extended release) 50 mg Qty 180 with 1 refill is not medically necessary. The injured worker has chronic and myofascial pain. The California MTUS Guidelines state that the ongoing management of opioid therapy should include detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The submitted documentation did not include a detailed pain assessment to establish adequate pain relief with the use of Ultram ER. Additionally, there was also no evidence of lack of adverse effects and aberrant behaviors. Moreover a urine drug screen was not submitted to verify appropriate medication use or a frequency of use. Furthermore, the medication was previously modified on 01/07/2015 from a quantity of #180 to #90 for weaning purposes. In the absence of the documentation showing details regarding the injured worker's medications, including her use of tramadol, and the appropriate documentation to support the ongoing use of opioids, the request is not supported. As such, the request for 1 prescription for Ultram ER (extended release) 50 mg Qty 180 with 1 refill is not medically necessary.

**Voltaren Gel (Diclofenac Sodium Topical Gel) 1% 100 gm tube, Qty 3:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** In regard to the request for Voltaren Gel (Diclofenac Sodium Topical Gel) 1% 100 gm tube, Qty 3, the request is not medically necessary. The injured worker has myalgia and chronic pain. The California MTUS Treatment Guidelines recommend Voltaren gel 1% for the relief of osteoarthritis pain in joints that lend themselves to topical treatment such as ankle, elbow, foot, hand, knee, and wrist. The guidelines further state that it has not been evaluated for treatment of the spine, hip, or shoulder. The documentation submitted for review failed to provide evidence that the use of Voltaren gel 1% was indicated for the relief of pain in the shoulder. Given the above, the request is not supported by the guidelines. As such, the request for Voltaren Gel (Diclofenac Sodium Topical Gel) 1% 100 gm tube, Qty 3 is not medically necessary.

**Norco Tablets 10/325 mg Qty 180 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use On-Going Management Page(s): 76-78.

**Decision rationale:** In regard to the request for Norco Tablets 10/325 mg Qty 180 with 1 refill, the request is not medically necessary. The injured worker has myalgia and chronic pain. The California MTUS Treatment Guidelines state that the ongoing management of opioid therapy should include detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The submitted documentation did not include a detailed pain assessment to establish adequate pain relief with the use of Norco. Additionally, there was also no evidence of lack of adverse effects and aberrant behaviors. Moreover, a urine drug screen was not submitted to verify appropriate medication use. Furthermore, the documentation submitted for review provides evidence of a previous determination of the medication being modified on 01/07/2015 from quantity #180 tablets to #90 tablets for weaning purposes. Given the above, the request as submitted is not supported by the guidelines. As such, the request for Norco Tablets 10/325 mg Qty 180 with 1 refill is not medically necessary.

**Hylagan injection, Left Shoulder, Qty 3:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Hyaluronic acid injections.

**Decision rationale:** The request for Hylagan injection, Left Shoulder, Qty 3 is not medically necessary. The injured worker has left shoulder pain. The Official Disability Guidelines do not recommend hyaluronic acid injections in the shoulder. Given the above, the request as submitted is not supported by the guidelines. As such, the request for Hylagan injection, Left Shoulder, Qty 3 is not medically necessary.