

Case Number:	CM13-0024427		
Date Assigned:	11/20/2013	Date of Injury:	09/20/2006
Decision Date:	02/03/2014	UR Denial Date:	08/30/2013
Priority:	Standard	Application Received:	09/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Ohio and Texas. 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 physician 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 patient is a 74-year-old injured worker who reported injury on 09/20/2006. The mechanism of injury was not provided. The patient was noted to have severe excruciating pain in the left shoulder radiating into the neck and deltoid. The patient's diagnosis was noted to include shoulder adhesive capsulitis. The request was for medication refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg Q6 hours PRN, quantity 20: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol; Ongoing Management Page(s): 82,93,94,113;78.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines, states Central analgesics drugs such as Tramadol (Ultram[®]) are reported to be effective in managing neuropathic pain and it is not recommended as a first-line oral analgesic. California MTUS recommend that there should be documentation of the 4 A's for Ongoing Monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The clinical documentation submitted for review indicated the patient was using tramadol for

breakthrough pain. However, there was a lack of documentation of the "4 A's" to support ongoing usage. The request for tramadol 50 mg Q6 hours PRNM quantity 20, is not medically necessary and appropriate.

Omeprazole 20mg BID, quantity 60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines recommends PPI's for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review indicated the physician was prescribing this medication prophylactically as it indicated the patient had GI symptoms secondary to medication and as a GI protectant. The clinical documentation submitted for review failed to provide the efficacy of the requested medication. The request for omeprazole 20 mg twice a day quantity 60, is not medically necessary and appropriate.

Voltaren gel 1% 300mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 112.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend Voltaren gel 1% for treatment of the spine, hip or shoulder. The clinical documentation indicated that the physician would be giving the patient a trial of Voltaren gel as a topical anti-inflammatory for their left shoulder. However, there is a lack of documentation to warrant nonadherence to guideline recommendations. The request or Voltaren gel 1% 300 mg is not medically necessary and appropriate.

Dendracin lotion: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation <http://www.drugs.com/edi/dendracin-lotion.html>

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Dendracin, Online Drug Insert Page(s): 105,111.

Decision rationale: According to the online drug insert, Dendracin includes methyl salicylate, benzocaine and menthol and it is used for: Temporary relief of minor aches and pains caused by

arthritis, simple backache, and strains. The California MTUS Chronic Pain Medical Treatment Guidelines, states, Topical Salicylates are recommended and topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The clinical documentation submitted for review indicated that the patient had failed a trial of Neurontin. The clinical documentation indicated that the medication Dendracin lotion was beneficial in reducing neuropathic symptoms in the right lower extremity but did not appear to be beneficial in reducing the pain in the left shoulder. There was a lack of documentation indicating the patient had trialed an anticonvulsant and there was a lack of quantity requested. The request for Dendracin lotion is not medically necessary and appropriate.