

<b>Case Number:</b>	CM13-0038972		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	11/10/2009
<b>Decision Date:</b>	07/29/2014	<b>UR Denial Date:</b>	09/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2013

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Mississippi. 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/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 injured worker is a 48-year-old female who was reportedly injured on 11/10/2009. The mechanism of injury was noted as a neck and right shoulder injury after lifting boxes of wine overhead onto a shelf. The injured worker underwent right shoulder subacromial decompression, extensive debridement on 4/19/2010 and a permanent spinal cord stimulator implantation on 12/11/2012. The most recent progress notes dated 7/8/2013 and 8/16/2013 indicated that there were ongoing complaints of cervical pain with left upper extremity radicular symptoms. Physical examination demonstrated positive Adson and Spurling Test, pain with cervical flexion and extension, decreased sensation in C6 dermatome, decreased right shoulder range of motion and strength, trapezius and rhomboid spasms and decreased strength of the left upper extremity. Magnetic resonance image (MRI) of the cervical spine, dated 5/5/2010, showed multi-level degenerative loss of disk space signal, 1 mm-2 mm disk bulges at C5-C6 and C6-C7 without spinal stenosis. MRI of the brachial plexus, dated 6/20/2011, was unremarkable. Electromyogram/nerve conduction study (EMG/NCS) of the upper extremities, dated 1/20/2012, revealed electrophysiological evidence of right carpal tunnel syndrome. Diagnoses: Complex regional pain syndrome, right rotator cuff tear status post surgery, cervical strain, thoracic outlet syndrome, chronic pain and multiple gastrointestinal complaints. Previous treatment included physical therapy, trigger point injections, right stellate ganglion blocks, brachial plexus blocks, transcutaneous electrical nerve stimulator, cervical Botox injections, shoulder cortisone injections, home exercises and medications include: Gabapentin, tramadol, cyclobenzaprine, Dendracin Lotion, Prilosec and Zofran. A request was made for Dendracin Lotion 120 ml, Cyclobenzaprine 7.5 mg #60, Gabapentin 600 mg #90, Tramadol ER 150 mg #30, Ondansetron 8 mg #10 and Prilosec 20 mg #60 and was not certified in the utilization review on 9/4/2013.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Dendracin lotion 120ml:** Upheld

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

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

**Decision rationale:** Topical analgesics are largely experimental and primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The topical product in question contains Methyl Salicylate, Benzocaine and Menthol. Guidelines do not support all of the ingredients and state that "any compound product that contains at least one drug (or drug class), that is not recommended, is not recommended". As such, the request is considered not medically necessary.

**Cyclobenzaprine 7.5mg #60 one BID PRN:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 41, 64.

**Decision rationale:** The California Medical Treatment Utilization Schedule supports the use of skeletal muscle relaxants for the short-term treatment of pain but advises against long-term use. Given the claimant's date of injury and clinical presentation, the guidelines do not support this request for chronic pain. As such, the request is not medically necessary.

**Gabapentin 600mg #90 one TID:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 16-17.

**Decision rationale:** The California Medical Treatment Utilization Schedule considers Gabapentin to be a first-line treatment for neuropathic pain. Based on the clinical documentation provided, there is a diagnosis of neuropathic pain. As such, the request is medically necessary.

**Tramadol ER 150mg #30 one daily as needed:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids and Tramadol Page(s): 82, 113.

**Decision rationale:** California Medical Treatment Utilization Schedule guidelines support the use of Tramadol for short-term use after there has been evidence of failure of a first-line option, evidence of moderate to severe pain and documentation of improvement in function with the medication. Given the clinical presentation and lack of documentation of functional improvement with this medication, the request is considered not medically necessary.

**Ondansetron 8mg #10 when needed for nausea:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic); Antiemetic.

**Decision rationale:** Ondansetron (Zofran) is a serotonin 5-HT<sub>3</sub> receptor antagonist. It is food and Drug Administration approved for nausea and vomiting secondary to chemotherapy, radiation treatment, post-operatively and acute gastroenteritis. The Official Disability Guidelines do not recommend this medication for nausea and vomiting secondary to chronic opiate use. Review of the available medical records revealed multiple gastrointestinal complaints but failed to document any of the criteria listed in the guidelines. As such, this request is considered not medically necessary.

**Prilosec 20mg #60 one BID PRN:** Upheld

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

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

**Decision rationale:** Prilosec (Omeprazole) is a proton pump inhibitor for patients at risk for gastrointestinal events. California Medical Treatment Utilization Schedule supports their use for preventing gastric ulcers induced by non-steroidal anti-inflammatory drug (NSAID). There are numerous proton pump inhibitors available over-the-counter without a prescription. Review of the available medical records revealed multiple gastrointestinal complaints; however, there was no clinical documentation of ongoing oral NSAID use. As such, it is considered not medically necessary per the guidelines.