

<b>Case Number:</b>	CM13-0049548		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	01/20/2011
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	10/29/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/08/2013

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain medicine and is licensed to practice in California. 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:

This is 42 year old male patient who reported an industrial injury to the left shoulder and lower back on 1/20/2011, over 3 years ago, attributed to the performance of customary job tasks. The patient was diagnosed with left shoulder impingement syndrome with bicipital tendinitis and rotator cuff/AC joint inflammation and lumbar spine DDD with radiculopathy; and discogenic cervical condition with upper extremity radicular components, facet inflammation, and muscle tightness. The patient complained of low back and left shoulder pain which occurs on a daily basis and increases with cold weather. The patient reported spasms of the left shoulder with numbness and tingling. The patient reported continuous back pain. The patient was noted to have prior corticosteroid injections the left shoulder without sustained relief. The objective findings on examination included no acute distress; left shoulder abduction to 85; right upper extremity abduction to 160; tenderness to the low back. 2/8/12 electrodiagnostic studies showed no evidence of lumbosacral radiculopathy. The treatment plan included Acetadryl #50 for insomnia; LidoPro cream for topical use; Neurontin 600 mg #90; Tramadol ER 150 mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ACETADRYL #50:** 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 Page(s): 11-12, 16-17. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter--insomnia.

**Decision rationale:** There is no clear description in the records of the specifics of this patient's "sleep disorder". Whether it is sleep initiation, sleep latency, or any attempts at weaning this medication. There is little discussed with respect to adequate sleep hygiene in an attempt to discontinue this medication. The documentation does not justify the need to provide this comp on medication as opposed to its constituents individually. Continued use was not justified.

**LIDOPRO CREAM:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines anti-inflammatory medications; chronic pain chapter's topical analgesics Page(s): 67-68; 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter--medications for chronic pain.

**Decision rationale:** The guidelines states that lidocaine (in creams, lotions, or gels) is not recommended for topical applications. Lidoderm patches have received warfarin status for topical applications. Nevertheless, it can be justified for a localized neuropathic pain syndrome when there has been failure of antiepileptic's including gabapentin and antidepressants. There is no clear description of any localized neuropathic pain syndrome other than shoulder pain and low back pain. Recommendation: Is not medically necessary.

**NEURONTIN 600 MG #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines chronic pain chapter revised 8/8/08 gabapentin Page(s): 110, 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-medications for chronic pain; anti-epilepsy drugs;.

**Decision rationale:** The provider has prescribed Gabapentin (Neurontin) 600 mg #90 and there is a reported neuropathic pain issue. There is no clear description of any radiating pain in a dermatomal distribution. The patient is stated to have neuropathic pain for which the patient has been prescribed Gabapentin/Neurontin. The prescription of Gabapentin (Neurontin) was not demonstrated to have been effective for the patient for the chronic pain issues. The provider does not provide objective findings on examination to support the presence of neuropathic pain for the cited diagnoses. The ACOEM Guidelines revised chronic pain chapter states that there is insufficient evidence for the use of Gabapentin or Lyrica for the treatment of axial lower back

pain, chronic lower back pain, or chronic lower back pain with radiculopathy. The CA MTUS and the Official Disability Guidelines state that there is insufficient evidence to support the use of Gabapentin or Lyrica for the treatment of chronic axial lower back pain.

**TRAMADOL ER 150 MG #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines opioids for chronic pain Page(s): 80-82. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-chronic pain medications; opioids.

**Decision rationale:** The prescription for Tramadol 150 mg #30 for short acting pain relief is being prescribed as an opioid analgesic for the treatment of chronic shoulder and back pain. There is no objective evidence provided to support the continued prescription of opioid analgesics for chronic pain reported to the left shoulder and lower back. There is no documented functional improvement from this opioid analgesic. The ACOEM Guidelines and CA MTUS do not recommend opioids for long-term treatment of chronic lower back and shoulder pain. The chronic use of Tramadol is not recommended by the CA MTUS; the ACOEM Guidelines or the Official Disability Guidelines for the long-term treatment of chronic pain only as a treatment of last resort for intractable pain. The prior adverse determination also mentioned the potential risk of tramadol concurrently with Zoloft (combining these medications can increase the risk of serotonin syndrome). It has not been established that there has been adequate trials and failures of first-line agents. The documentation does not describe objective and ongoing subjective analgesia, or that there has been adequate and ongoing appropriate monitoring including urine drug screens. Recommendation: Is not medically necessary.