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| <b>Case Number:</b>   | CM13-0050990 |                              |            |
| <b>Date Assigned:</b> | 12/27/2013   | <b>Date of Injury:</b>       | 08/31/2009 |
| <b>Decision Date:</b> | 03/11/2014   | <b>UR Denial Date:</b>       | 10/30/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/13/2013 |

### 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 Illinois 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 52-year-old female who reported an injury on 08/31/2009. The patient is currently diagnosed with a lumbar discopathy, right shoulder impingement syndrome, rule out cervical radiculitis, left shoulder impingement syndrome and rule out rotator cuff pathology. The patient was seen by [REDACTED] on 09/17/2013. The patient reported persistent pain in the lower back with radiation to the bilateral lower extremities. Physical examination revealed tenderness to palpation of the bilateral shoulders, tenderness to palpation of the lumbar spine, positive straight leg raise and dysesthesia at the L5 and S1 dermatomes. Treatment recommendations included a referral to pain management for a lumbar epidural steroid injection and continuation of current medications as well as chiropractic treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**100 Naproxem 550 mg (Express Scripts): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** The California MTUS Guidelines state that NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. Additionally, the California MTUS Guidelines state that there is no evidence of long-term effectiveness for pain or function. The medical necessity for the ongoing use of this medication has not been established; therefore, the request is non-certified.

**120 Omeprazole DR 20mg (Express Scripts): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** The California MTUS Guidelines state that proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet the criteria for the use of this medication. As such, the request is non-certified.

**90 Tramadol ER 150mg (Express Scripts): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. A satisfactory response to treatment has not been indicated. Therefore, the request is non-certified.