

<b>Case Number:</b>	CM14-0102403		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	11/28/2008
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	06/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2014

### 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 Occupational Medicine and is licensed to practice in Colorado. 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 male with a date of injury of November 28, 2008. He was transferring a patient at the time of injury. A clinic note of June 13, 2014 reflects a follow up with worsening neck and shoulder symptoms. Her pain level is 9-10/10 and the pain is constant with over head lifting. Her back and wrists continue to cause pain as well. On exam there is tenderness, functional motion, reflexes are +2, there is normal gait, tenderness to paralumbar palpation, motor is 5/5, shoulder testing is negative and noted tenderness at the greater tuberosity, acromioclavicular joint tenderness, and positive acromioclavicular joint compression test. There is tenderness at the wrists and ankle and foot with normal motion. Diagnosis is right and left shoulder impingement syndrome, degenerative disc disease of cervical spine, low back, chest, and right foot pain. The request is for Omeprazole, Tramadol, Diclofenac, and a urine drug screen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Omeprazole 20mg, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

**Decision rationale:** This medication is utilized for dyspepsia and there is no indication of dyspepsia symptoms or high risk factors identified in this injured worker. The medical treatment guidelines support the use in individuals identified to have dyspepsia and who are at high risk for gastrointestinal events from high dose/multiple nonsteroidal anti-inflammatory drugs. The request does not meet the criteria of the guidelines and is therefore not considered medically necessary.

**Tramadol ER , #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS FOR OSTEOARTHRITIS Page(s): 84.

**Decision rationale:** Ongoing prescribing of a medication requires documentation of effectiveness. While the injured worker is chronically prescribed this medication, the medical records do not reflect any improvement of pain, or that the medication is providing any benefit as required by the medical treatment guidelines. The medical records reflect ongoing pain rated 9-10/10 with no indication of any functional improvement, side effects, or aberrant use. Therefore, the requested Tramadol is not considered medically necessary.

**Diclofenac XR 100mg, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Diclofenac/Voltaren Page(s): 75.

**Decision rationale:** According to workers compensation guidelines, long-term use of this drug is not recommended. The medical record reflects a lack of effectiveness and there is no documentation of review of liver, cardiac, or gastrointestinal conditions that may contraindicate the use of this medication. Therefore, the ongoing prescribing of this medication is not considered medically necessary.

**Urine drug screen Qty 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 43.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines DRUG TESTING Page(s): 43.

**Decision rationale:** There is a lack of documentation of prior drug screening performed in January 2014, and there is a lack of documentation of expected issues of abuse or addiction. The medical treatment guidelines recommend urine drug screen to assess for the use of the presence of illegal drugs. The guidelines further state ongoing management of workers taking opioid medications should include use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. Therefore, the requested service is not considered medically necessary.