

Case Number:	CM14-0023680		
Date Assigned:	06/11/2014	Date of Injury:	01/14/2011
Decision Date:	08/22/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	02/25/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

The patient is a 38-year-old female who has submitted a claim for chronic low back pain, degenerative lumbar spondylosis, chronic low back pain, myofascial pain syndrome, chronic neck pain, degenerative cervical spondylosis, and chronic shoulder pain associated with an industrial injury date of January 14, 2011. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of shoulder, neck and low back pain radiating into the right leg. Patient also complains of depression. Physical examination revealed surgical scarring at the right shoulder. There was limited range of motion of the right shoulder. There was deconditioning at the lumbar spine with poor muscle tone, limited range of motion with spasm in the lumbar paraspinal muscles. Sensation to light touch was decreased on the right hand and right foot. Patrick's test was positive bilaterally. There was tenderness at the base of the neck and over the trapezius area. Cervical spine range of motion was limited. Treatment to date has included physical therapy, right shoulder arthroscopy (9/19/11), right shoulder subacromial decompression, debridement of subscapularis tear and AC joint arthroplasty, AC joint injections, chiropractic treatment, epidural steroid injections, right shoulder surgery (5/2013) and medications, which include Vicodin, Norco 10/325mg, Prilosec 20mg, Trazodone 50mg and Voltaren gel. Utilization review from February 12, 2014 modified the request for Trazodone 50mg BID #60 and Voltaren gel to Trazodone 50mg BID #60 and Voltaren gel x 1 month. Details of the modification and rationale for determination were not included in the records for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRILOSEC 20MG EVERY DAY (QD) #30: 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, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: According to page 68 of the CA MTUS Chronic Pain Medical Treatment Guidelines, proton pump inhibitors are recommended for patients at intermediate risk for gastrointestinal events. Risk factors for gastrointestinal events include age >65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulants; or high dose/multiple NSAIDs. In this case, the patient has been on Omeprazole since November 2013. It was prescribed for GERD however, recent progress reports did not reveal any complaint of gastrointestinal distress which may necessitate a proton pump inhibitor. There was no subjective report that he was experiencing heartburn, epigastric burning sensation or any GI symptom. Patient also does not have history of peptic ulcer, GI bleeding or perforation. Therefore, the request for PRILOSEC 20MG EVERY DAY (QD) #30 is not medically necessary.

TRAZADONE 50MG TWICE A DAY (BID) #60: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Trazodone (Desyrel).

Decision rationale: CA MTUS does not specifically address Trazodone (Desyrel). Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that trazodone is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. There is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression. In this case, patient has been taking Trazodone since 11/15/2013 for insomnia. Review of records indicate that while the patient does not fulfill the criteria for Major Depression, she does have a significant affective or emotional pain component that contributes to her chronic disabling pain syndrome. Patient reports moderately disturbed sleep and insomnia contributes to her depression through fatigue. She reports ongoing and increasing depression because of her pain, inability to work and financial stresses. Guideline criteria were met. Therefore, the request for TRAZADONE 50MG TWICE A DAY (BID) #60 is medically necessary.

VOLTAREN GEL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2, Topical Analgesics Page(s): 112.

Decision rationale: According to page 112 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Voltaren Gel 1% (diclofenac) is indicated for relief of osteoarthritic pain in joints that lend themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of spine, hip, or shoulder. In this case, the patient has been on Voltaren since November 2013. It was prescribed in conjunction with oral pain medications. However, the use of Voltaren is not in accordance with guideline recommendations as there is little evidence for its use for back pain and shoulder pain, which the patient complains of. The medical records also failed to provide evidence of osteoarthritis, which may warrant the use of Voltaren gel. The request also failed to specify the dosage and the number to be dispensed. The medical necessity was not established. Therefore, the request for Voltaren Gel is not medically necessary.