

Case Number:	CM14-0057344		
Date Assigned:	07/09/2014	Date of Injury:	03/23/2007
Decision Date:	08/11/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/29/2014

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 Physical Medicine and Rehabilitation 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 injured worker is a 56 year old female who reported an injury on 03/23/2007 from an unknown mechanism of injury. The injured worker has a history of neck and left shoulder pain. The clinical note dated 03/21/2014 revealed the patient continued to have significant pain in her back and left shoulder without any improvement. Objective findings of the cervical spine revealed tenderness over the paracervical musculature, positive muscle spasms in the paracervical musculature. Motor testing is 5/5 to all muscle groups of the upper extremity. There was diminished sensation in the C6 nerve root distribution, left upper extremity. Range of motion to the cervical spine: flexion at chest to chin. There was pain with extension and lateral bend left at 30 degrees. The rotation to left and right was at 30 degrees. The right shoulder exam revealed a positive Neer's test and post Hawkins test. The right shoulder range of motion showed abduction 170 degrees, forward flexion 170 degrees, internal rotation 60 degrees, external rotation 80 degrees. The injured worker had a diagnosis of frozen left shoulder, rotator cuff tendonitis left shoulder, and status post left shoulder rotator cuff repair, subacromial decompression, acromioclavicular joint resection, right shoulder impingement syndrome, cervical strain, cervical radiculopathy left upper extremity C6 nerve root distribution, and depression. There were no diagnostic studies provided. There were no prior treatments provided. Medications included Diclofenac XR 100 mg, Omeprazole 20 mg, Prophylaxis 30 tabs, and Tramadol ER.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg Tablet #30: 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): 68-69.

Decision rationale: The MTUS Chronic Pain Guidelines state Proton Pump Inhibitors may be recommended for patients taking NSAIDs who have a greater risk for gastrointestinal events or for those with dyspepsia related to NSAID use. There was lack of documentation for the effectiveness of the stated medication. Also, there is lack of documentation that the injured worker had a risk for gastrointestinal events or significant complaints of dyspepsia. Additionally there is no frequency for the medication submitted within the request. As such, the request is not medically necessary and appropriate.

Tramadol ER 150mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

Decision rationale: According to the MTUS Chronic Pain Guidelines, the ongoing management of patients taking opioid medications should include routine office visits and detailed documentation of the extent of pain relief, functional status in regards to activities of daily living, appropriate medication use and/or aberrant drug-taking behaviors, and adverse side effects. The pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. The medical records provided for review lack documentation to support the continued use of the stated medication. The MTUS Guidelines also recommend documentation of the following when monitoring for medication effectiveness; analgesia (pain relief), activities of daily living (psychosocial functioning), adverse effects (side effects), and aberrant drug taking (addiction-related outcomes). There is lack of documentation for the side effects, pain relief, and frequency of relief for the stated medication. There is no urine drug testing provided. Additionally, there was no frequency for the medication stated within the request. As such, the request is not medically necessary and appropriate.

Diclofenac XR 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43 70 68 and 78-84.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

Decision rationale: The MTUS Chronic Pain Guidelines state that Diclofenac/NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. There was lack of documentation for the effectiveness of the stated medication. Additionally, there was no frequency for the medication stated within the request. As such, the request is not medically necessary and appropriate.