

Case Number:	CM14-0098043		
Date Assigned:	07/28/2014	Date of Injury:	09/09/1999
Decision Date:	09/26/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	06/26/2014

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 Nevada. 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 records, presented for review, indicate that this 71 year old male was reportedly injured on September 9, 1999. The mechanism of injury is undisclosed. The most recent progress note, dated July 16, 2014, indicated that there were ongoing complaints of right shoulder pain. The physical examination demonstrated a 5'10", 190 pound individual with a normal gait pattern, tenderness to palpation over the sacroiliac joint on the left with a decreased lumbar spine range of motion, Patrick's test was negative, and straight leg raise was negative. Diagnostic imaging studies were not presented for review. Previous treatment included multiple medicines, injections, physical therapy, and pain management interventions. A request was made for multiple medications and was not certified in the preauthorization process on June 12, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for 1 prescription of Ultram ER 300 mg #30 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 113.

Decision rationale: This medication is a centrally acting synthetic opioid analgesic that requires the lowest dose to use that allows for functional improvement or decrease in pain complaints. Based on the progress notes presented for review, there is no clinical indication that there is any functional improvement. Furthermore, the pain levels continued to be the same. Therefore, this is not clear that this medication has demonstrated any efficacy. Accordingly, the medical necessity has not been established.

Prospective request for 1 prescription of Celebrex 200 mg #30 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 30, 70.

Decision rationale: As noted in the Medical Treatment Utilization Schedule (MTUS), this nonsteroidal antiinflammatory is a traditional first line treatment. However, based on the physical examination reported, and the ongoing complaints of pain, there is no clinical indication presented that this medication is completing its intended goals. Therefore, with no significant efficacy or utility objectified, the continued chronic use of this medication is not supported. Therefore, the medical necessity has not been established.

Prospective request for 1 prescription of Voltaren gel 2 gm #2 tubes with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

Decision rationale: Voltaren gel is a topical nonsteroidal antiinflammatory drug (NSAID) indicated for the relief of osteoarthritic pain of the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. Outside of the treatment of osteoarthritis, there's no other clinical indication for the use of this medication. There is no documentation of osteoarthritis in the clinical notes provided. As such, the request is considered not medically necessary.