

<b>Case Number:</b>	CM15-0007020		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	03/11/2009
<b>Decision Date:</b>	08/28/2015	<b>UR Denial Date:</b>	12/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Indiana, Oregon  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 43 year old female with an industrial injury dated 10/09/2012. The mechanism of injury is documented as a fall. Her diagnoses included cervical sprain/strain, thoracic sprain/strain/and lumbar region, r/o Radiculopathy, biceps tendonitis. Prior treatment included medications. She presents on 12/08/2014 with complaints of neck, mid back, low back, bilateral wrist/hands and bilateral knee pain. Range of motion of the cervical spine and lumbar spine was decreased. Treatment plan included request for medications (Ultram, Prilosec and pain cream), cervical epidural injections, left shoulder surgery, lumbar epidural injection, urine toxicology screen and follow up and x-rays. The treatment request is for Ultram 50 mg, Prilosec 20 mg, Gaba/Flur compound cream, cervical epidural injection at left cervical 4-5, left shoulder arthroscopic exam with repair verses debridement with acromioplasty, lumbar epidural injection at lumbar 4-5, urine toxicology screen and x-ray A/P of bilateral feet and X-ray A/P of thoracic spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultram 50mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ultram (Tramadol).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines tramadol Page(s): 93.

**Decision rationale:** Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 93-94, Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is indicated for moderate to severe pain. Tramadol is considered a second line agent when first line agents such as NSAIDs fail. There is insufficient evidence in the records of failure of primary over the counter non-steroids or moderate to severe pain to warrant Tramadol. Therefore, use of Tramadol is not medically necessary.

**Prilosec 20mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain.

**Decision rationale:** The CA MTUS does not address proton pump inhibitors such as Nexium and Protonix. According to the Official Disability Guidelines, Pain section, regarding Proton pump inhibitors (PPIs), Recommended for patients at risk for gastrointestinal events. Healing doses of PPIs are more effective than all other therapies, although there is an increase in overall adverse effects compared to placebo. Nexium and Prilosec are very similar molecules. For many people, Prilosec is more affordable than Nexium. Nexium is not available in a generic (as is Prilosec). In this particular case there is insufficient evidence in the records that the patient has gastrointestinal symptoms or at risk for gastrointestinal events. Therefore, the request is not medically necessary.

**Gaba/Flur compound cream:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

**Decision rationale:** Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112 largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended for topical use. Therefore the request is not medically necessary.

**Urine tox screen:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines urine toxicology Page(s): 94.

**Decision rationale:** Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 94-95, use of urine toxicology is encouraged particularly when opioids are prescribed. It states, Opioids, steps to avoid misuse/addiction. The following are steps to avoid misuse of opioids, and in particular, for those at high risk of abuse: a) Opioid therapy contracts. See Guidelines for Pain Treatment Agreement. b) Limitation of prescribing and filling of prescriptions to one pharmacy. c) Frequent random urine toxicology screens. In this case there is insufficient evidence of chronic opioid use or evidence of drug misuse to warrant urine toxicology. The request is not medically necessary.

**X-ray A/P of bilateral feet:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 373.

**Decision rationale:** CA MTUS/ACOEM chapter 14, ankle and foot complaints, page 373 recommends foot x-ray be done for trauma or presence of red flag symptoms. In this case no red flag symptoms exist and there is no rationale provided why x-ray is required at this time. Based on this the request is not medically necessary.

**X-ray A/P of thoracic spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 296.

**Decision rationale:** CA MTUS/ACOEM chapter 12, low back complaints, page 296 recommends spine x-ray be done for trauma or presence of red flag symptoms. In this case, there are no red-flag symptoms and no rationale why radiographs are needed. The request is not medically necessary.

**Cervical epidural injection at left C4-5:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid Page(s): 46.

**Decision rationale:** According to the CA MTUS/ Chronic Pain Medical Treatment Guidelines, Epidural Steroid injections page 46; The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. There must be evidence that the claimant is unresponsive to conservative treatment (exercises, physical methods, NSAIDs, and muscle relaxants). In this case the exam notes do not demonstrate a Radiculopathy that is specific to a dermatome on physical exam. In addition, there is lack of evidence of failure of conservative care. Therefore, the request is not medically necessary.

**Lumbar epidural injection at left L4-5: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid Page(s): 46.

**Decision rationale:** According to the CA MTUS Chronic Pain Medical Treatment Guidelines, page 46; Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of Radiculopathy). Specifically the guidelines state that Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. In addition there must be demonstration of unresponsiveness to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case the exam notes cited do not demonstrate a failure of conservative management or a clear evidence of a dermatomal distribution of Radiculopathy. Therefore the request is not medically necessary.

**Left shoulder arthroscopic exam with repair vs debridement with acromioplasty: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery

recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. Other features in this case are that there are findings on the MRI which are typically considered surgical pathologies which are not addressed in this request. The clinical information provided does not satisfy the guideline conditions above and is not medically necessary.