

Case Number:	CM14-0125054		
Date Assigned:	08/08/2014	Date of Injury:	11/27/2010
Decision Date:	10/10/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/06/2014

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 Tennessee. 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:

This 52-year-old male patient had a date of injury on 11/27/2010. The mechanism of injury was not noted. In a progress noted dated 7/22/2014, subjective findings included more swelling and discomfort chest. His upper back pain is 6/10, forearm pain is 8/10 with numbness and tingling. PT sessions are beneficial in increasing ROM and relaxing muscles but pain is same. On a physical exam dated 7/22/2014 objective findings included limited ROM of left shoulder, left shoulder pain with movement, decreased grip strength in left hand. The diagnostic impression shows cervical sprain/strain of neck, cervical radiculitis, sprain/strain left forearm, peripheral neuropathy Treatment to date: medication therapy, behavioral modification A UR decision dated 7/30/2014 denied the request for tramadol ER 150mg #30x4, stating tramadol is recommended for exacerbations of severe pain, and the need for tramadol on daily basis with lack of documented improvement in function is noted established. Flexeril 64mg #30x4 was denied stating long term use more than 2-3 weeks is not recommended. Omeprazole 20 #60x4 was denied, stating no evidence of GI symptoms with use of NSAIDs. Methoderm gelx2 was denied, stating that there was no evidence oral antidepressants or anticonvulsants has failed, and topical analgesics are not recommended if oral agents have failed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol ER 150mg #30 4 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): 113.

Decision rationale: CA MTUS states that Tramadol (Ultram) is not recommended as a first-line oral analgesic. This medication has action on opiate receptors, thus criterion for opiate use per MTUS must be followed. In a progress report dated 7/22/2014, there was no documented functional improvement noted with the opioid regimen, and the patient is documented to be on tramadol since at least 4/25/2014. Furthermore, there was no evidence of pain contract or urine drug screens provided for review. Therefore, the request for tramadol 150mg #30 with 4 refills is not medically necessary.

Cyclobenzaprine 75mg # 30 4 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41-42.

Decision rationale: According to page 41 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. In a progress report dated 7/22/2014, there was no documentation of an acute exacerbation of pain to justify use of this medication. Furthermore, this patient is documented to be on this medication since at least 3/25/2014, and guidelines do not support long term use due to risk of dependency. Therefore, the request for flexeril 7.5 mg #30 x4 refills is not medically necessary.

Omeprazole 20mg #60 4 refills: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter

Decision rationale: CA MTUS and the FDA support proton pump inhibitors in the treatment of patients with GI disorders such as; gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy. Omeprazole is a proton pump inhibitor, PPI, used in treating reflux esophagitis and peptic ulcer disease. There is no comment that relates the need for the proton pump inhibitor for treating gastric symptoms associated with the medications used in treating this industrial injury. In general, the use of a PPI should be limited to the recognized

indications and used at the lowest dose for the shortest possible amount of time. In a progress report dated 7/22/2014, this patient is noted to be on Naproxen, an NSAID known to cause gastrointestinal events. Therefore, the request for omeprazole 20mg #60 is medically necessary.

Menthoderm Gel 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: CA MTUS states that topical salicylates are significantly better than placebo in chronic pain. However, while the guidelines referenced support the topical use of mental salicylates, the requested Menthoderm has the same formulation of over-the-counter products such as [REDACTED]. It has not been established that there is any necessity for this specific brand name. It is recommended that the Menthoderm topical be modified to allow for an over-the-counter formulation. In a progress report dated 7/22/2014, there was no discussion of failure of a 1st line oral analgesic to justify use of this medication. Furthermore, it was unclear why this patient was not prescribed over the counter formulations such as [REDACTED], and why he would need a prescription medication such as Menthoderm. Therefore, the request for Menthoderm Gel x 2 refills is not medically necessary.