

Case Number:	CM13-0053439		
Date Assigned:	12/30/2013	Date of Injury:	11/07/2011
Decision Date:	03/11/2014	UR Denial Date:	11/08/2013
Priority:	Standard	Application Received:	11/18/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 physician 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 33-year-old female with date of injury on 11/07/2011. The progress report dated 09/06/2013 by [REDACTED] indicates that patient's diagnoses include: (1) Cervical radiculopathy, (2) Cervical sprain/strain, (3) Thoracic sprain/strain, (4) Lumbar radiculopathy, (5) Lumbar sprain/strain, (6) Right shoulder impingement syndrome, (7) Right shoulder sprain/strain, (8) Right cubital tunnel syndrome, (9) Right elbow sprain/strain, (10) Right carpal tunnel syndrome, (11) Right wrist sprain/strain, (12) Sleep disturbance. The patient continues with complaints of significant pain in the cervical, thoracic, and lumbar spine as well as right shoulder, right elbow, and right wrist. Physical exam findings included decreased range of motion in the lumbar spine due to pain, decreased range of motion associated with pain in the right elbow and right wrist. The utilization review letter dated 11/08/2013 issued a non-certification for the following medications: Tramadol/L-carnitine, glucosamine sulfate, Terocin cream, flurbiprofen cream, gabacyclotram cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol/L-Carnitine 40/125mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 88-89.

Decision rationale: The patient continues with cervical, thoracic, and lumbar pain, as well as right shoulder, right elbow, and right wrist pain. The progress reports reviewed between 03/21/2013 and 09/06/2013 did not provide any information regarding reduced pain or improved function with the tramadol combination medication. The patient has been continued on Norco as well as tramadol. MTUS page 88 and 89 regarding long-term use of opioids states that pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The treating physician does not provide any of this documentation in the reports reviewed. Furthermore, Carnitine is a substance that helps metabolize fat. There is no rationale as to why this combination is being used. There are no guidelines that support the use of carnitine for chronic pain. Recommendation is for denial.

Glucosamine Sulfate 500 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

Decision rationale: The patient continues with significant pain in the cervical, thoracic, and lumbar spine as well as right shoulder, right elbow, and right wrist. MTUS Guidelines page 50 regarding glucosamine and chondroitin sulfate states that it is recommended as an option given that it is low risk in patients with moderate arthritis pain especially for knee osteoarthritis. The patient does not appear to have a diagnosis of osteoarthritis of the knee. The patient does not have any complaints of knee pain. Recommendation is for denial.

Terocin 240 ml:

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

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

Decision rationale: The patient continues with pain in the cervical, thoracic, and lumbar spine, right shoulder, right elbow, and right wrist. The patient has been provided with a flurbiprofen cream. MTUS Guidelines page 111 to 113 regarding topical nonsteroidal anti-inflammatories, MTUS specifically states that under indications, osteoarthritis and tendonitis, in particular that of the knee and elbow or other joints that are amenable to topical treatment. It further states that there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. This patient does appear to have symptoms of pain in the right elbow and right

wrist. Therefore, the topical NSAID may be indicated in this patient and appears to be reasonable. Therefore, authorization is recommended.

Gabacyclotram 180 gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The patient continues with pain in the cervical, thoracic, and lumbar spine as well as right shoulder, right elbow, and right wrist. The request for gabacyclotram is not supported by MTUS page 111 to 113 regarding topical analgesics which states any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Gabacyclotram contains Gabapentin, cyclobenzaprine and Tramadol. None of these are supported in topical formulation per MTUS. Recommendation is for denial.

Flubiprofen NAP Cream-LA 180 gm: Overturned

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

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

Decision rationale: The patient continues with pain in the cervical, thoracic, and lumbar spine, right shoulder, right elbow, and right wrist. The patient has been provided with a flurbiprofen cream. MTUS Guidelines page 111 to 113 regarding topical nonsteroidal anti-inflammatories, MTUS specifically states that under indications, osteoarthritis and tendonitis, in particular that of the knee and elbow or other joints that are amenable to topical treatment. It further states that there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. This patient does appear to have symptoms of pain in the right elbow and right wrist. Therefore, the topical NSAID may be indicated in this patient and appears to be reasonable. Therefore, authorization is recommended.