

Case Number:	CM13-0058579		
Date Assigned:	12/30/2013	Date of Injury:	03/03/2011
Decision Date:	06/04/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	11/27/2013

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 Orthopedic Surgery and is licensed to practice in Texas. 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 patient is a 52 year old male injured on 03/03/11 due to an undisclosed mechanism of injury. Neither the specific injuries sustained nor the initial treatments rendered were discussed in the documentation provided. Current diagnoses include cervicgia and C4-5 posterior disc bulge. The documentation dated 01/07/14 indicates the patient presented with complaints of neck pain, right arm and right shoulder pain with associated headaches and dysphasia. The patient has previously undergone platelet rich protein injection for lateral epicondylitis with improvement in her condition. Physical assessment revealed tenderness and spasms in the right paravertebral and trapezius musculature, Spurling positive to the right, diminished sensation in the right 3rd, 4th, and 5th fingers, strength 5/5 in all muscle groups, cervical range of motion decreased. There was no list of current medications provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL ER 150MG #30 X 2 BOTTLES PROVIDED ON 10/02/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids/Criteria For Use Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Tramadol 150mg cannot be established at this time.

THERAMINE ORAL SUPPLEMENT #90 TABS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Theramine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter (Chronic), Herbal Medicines.

Decision rationale: As noted in the Pain chapter of the ODG, the use of herbal medicines or medical foods is not recommended. There is no indication in the documentation that the patient has failed previous prescription medications or has obvious contraindications. Additionally, there is no indication that the patient cannot utilize the over-the-counter version of this medication. As such, the request for Theramine Oral Supplement #90 cannot be recommended as medically necessary.

DICLOFENAC 75MG BID #60 X 2 BOTTLES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68, 71.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs/Specific Drug List & Adverse Effects Page(s): 70.

Decision rationale: As noted on page 70 of the Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended as a second-line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute lower back pain. Package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). There is no documentation that these monitoring recommendations have been performed and the patient is being monitored on a routine basis. Additionally, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. As such, the request for Diclofenac 75mg BID #60 cannot be established as medically necessary.