

Case Number:	CM13-0069123		
Date Assigned:	01/03/2014	Date of Injury:	10/30/2005
Decision Date:	04/21/2014	UR Denial Date:	12/11/2013
Priority:	Standard	Application Received:	12/20/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine, 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 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 53 year old female who was injured on 10/30/05 when she felt pain in her back while cleaning. The right shoulder/trapezius, right thoracic, cervical spine, HBP, gastritis and right carpal tunnel have been accepted by the carrier. Prior treatment history has included acupuncture, chiropractic care, and shockwave treatment with partial temporary relief as well as hot and cold pack therapy without benefit. Medications include anti-inflammatory topical cream. The patient is status post anterior cervical discectomy at C4-6 and fusion with plate fixation and intradiscal peek cage on 2/12/09. She underwent arthroscopic repair of rotator cuff tear, acromioplasty, and resection of coracoacromial ligament and subacromial bursa of right shoulder on 10/8/12. Diagnostic studies reviewed include EMG/NCV dated 12/12/07 revealing acute right C6 radiculopathy. A urine drug screen dated 11/30/12 shows inconsistent results. A permanent and stationary report dated 5/7/13 states that the patient was advised to take Tramadol 2-3 times a day and Fioricet approximately twice a week.

IMR ISSUES, DECISIONS AND RATIONALES

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

360 TRAMADOL 50MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-82. Decision based on Non-MTUS Citation Essentials of Pain Medicine and Regional Anesthesia, 2nd Edition, 2005. Chapter 13: Opioid Therapy: Adverse Effects, Including Addiction, pages 113-123.

Decision rationale: As per the California MTUS guidelines, four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. In this case, the records indicate that this patient has chronic pain and has been prescribed Tramadol; however, there is no documentation of functional improvement or improved pain with the use of this medication. Also, guidelines recommend urine drug screening to monitor prescribed substance and issues of abuse, addiction or poor pain control. There is no documentation submitted of a recent urine drug screening. Thus, the request is non-certified.

360 OMEPRAZOLE 20MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: Omeprazole is a proton pump inhibitor (PPI). Per the California MTUS guidelines, PPIs are recommended for patients at intermediate risk for gastrointestinal events who do not have cardiovascular disease. In this case, there is no documentation of complaints of abdominal pain, GI events, or ulcers. Therefore, the medical necessity has not been established and the request is non-certified.

TRAMADOL CREAM: AMITRIPTYLINE 4%, TRAMADOL 20%, DEXTROMETHORPHAN 10%, 240 GRAMS: Upheld

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

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

Decision rationale: As per the California MTUS guidelines, topical analgesics are considered largely experimental in use with few randomized controlled trials to determine efficacy or safety. Guidelines indicate that many agents are compounded as monotherapy or in combination for pain control including opioids and antidepressants. There is little to no research to support the use of many of these agents. The guidelines do not support the use of Tramadol in a topical formulation. Further guidelines indicate that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Thus, the request is non-certified.