

Case Number:	CM14-0166342		
Date Assigned:	10/13/2014	Date of Injury:	12/15/2003
Decision Date:	12/03/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/09/2014

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 Internal Medicine, has a subspecialty in Rheumatology and is licensed to practice in Maryland. 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 female with date of injury 12/15/2003. The mechanism of injury is not stated in the available medical records. The patient has complained of left upper extremity and left lower extremity pain since the date of injury. She has been treated with steroid injections, physical therapy and medications. There are no radiographic reports included for review. Objective: decreased and painful range of motion of joints of left lower extremity; antalgic gait; left upper extremity edema. Diagnoses: complex regional pain syndrome upper extremity, chronic pain syndrome, pain involving the pelvic region and thigh. Treatment plan and request: Tramadol, Topiramate, Butrans 10 meq/hr.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol HCL tab 50mg Day Supply: 30 Quantity: 120 with 0 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiods, criteria for use Page(s): 76-85, 88-89.

Decision rationale: This 52 year old female has complained of left upper extremity and left lower extremity pain since date of injury 12/15/2003. She has been treated with steroid

injections, physical therapy and medications to include opioids for at least three months duration. The current request is for Tramadol. No treating physician reports adequately assess the patient with respect to function, specific benefit, return to work, signs of abuse or treatment alternatives other than opioids. There is no evidence that the treating physician is prescribing opioids according to the MTUS section cited above which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opiod contract and documentation of failure of prior non-opiod therapy. On the basis of this lack of documentation and failure to adhere to the MTUS guidelines, Tramadol is not indicated as medically necessary.

Topiramate tab 50mg Day Supply: 30 Quantity: 60 with 0 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 7, 21.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epileptic drugs Page(s): 21.

Decision rationale: This 52 year old female has complained of left upper extremity and left lower extremity pain since date of injury 12/15/2003. She has been treated with steroid injections, physical therapy and medications to include Topiramate for at least three months duration. The current request is for Topiramate. Per the MTUS guideline cited above, Topiramate is considered for use in neuropathic pain when other anit-epileptic agents have failed. There is no such documentation that other agents have been tried and failed in this patient. Nor is there clear docoumentation/ evidence of a neuropathic source of pain. On the basis of the MTUS guidelines and available medical documentation, Topiramate is not indicated as medically necessary in this patient.

Butrans DIS 10 mcg/hr Day Supply: 28 Quantity: 4 with 0 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 26.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiods, criteria for use Page(s): 76-85, 88-89.

Decision rationale: This 52 year old female has complained of left upper extremity and left lower extremity pain since date of injury 12/15/2003. She has been treated with steroid injections, physical therapy and medications to include opioids for at least three months duration. The current request is for Burtrans DIS. No treating physician reports adequately assess the patient with respect to function, specific benefit, return to work, signs of abuse or treatment alternatives other than opioids. There is no evidence that the treating physician is prescribing opioids according to the MTUS section cited above which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opiod contract and documentation of failure of prior non-opiod therapy. On the basis of this lack of DIS documentation and failure to adhere to the MTUS guidelines, Butrans is not indicated as medically necessary.

