

Case Number:	CM14-0022819		
Date Assigned:	06/11/2014	Date of Injury:	12/10/2010
Decision Date:	07/15/2014	UR Denial Date:	02/06/2014
Priority:	Standard	Application Received:	02/24/2014

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 Physical Medicine and Rehabilitation & Pain Management, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and 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 injured worker is a 53-year-old female with an injury reported on 12/10/2010. The mechanism of injury was not provided within the recent clinical notes. The clinical note dated 02/21/2014 reported that the injured worker complained of chronic low back pain with left lower extremity radiation, left shoulder pain, and left knee pain. The physical examination of the injured worker's left shoulder revealed tenderness to the rotator cuff, acromioclavicular joint, and anterior shoulder. It was reported the range of motion to the injured worker's left shoulder was decreased in the flexor and extensor muscles. The physical examination of the left lower extremities, revealed left knee tenderness with decreased range of motion demonstrating extension to 90 degrees and abduction to 45 degrees. The motor examination revealed decreased strength of the extensor and flexor muscles to the left lower extremity. The injured worker's diagnoses included left-sided knee pain; left shoulder pain; osteoarthritis of the left knee; left-sided shoulder bursitis; morbid obesity; chronic pain; status post left knee arthroscopy with residual; and NSAID intolerance. The provider requested tramadol and Enovarx-ibuprofen 10% kit. The rationale for tramadol was to reduce pain and the rationale for the Enovarx-ibuprofen was due to the injured worker's GI intolerance to oral NSAIDs. The Request for Authorization was submitted on 02/07/2014. The injured worker's prior treatments included acupuncture and physical therapy. It was reported that the injured worker failed to have a positive response to acupuncture and physical therapy. The date and amount of previous acupuncture and physical therapy were not provided within recent clinical note.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL 50MG THREE TIMES A DAY #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The injured worker complained of chronic low back pain with left lower extremity radiation, left shoulder pain, and left knee pain. The treating physician's rationale for tramadol is to reduce pain. The California MTUS guidelines state tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. There is a lack of clinical information provided documenting the efficacy of tramadol as evidenced by decreased pain and significant objective functional improvements. Moreover, there is a lack of documentation that the injured worker has had urine drug screens to validate proper medication adherence in the submitted paperwork. Given the information provided, there is insufficient evidence to determine appropriateness to warrant medical necessity; therefore, the request is not medically necessary and appropriate.

ENOVARX-IBUPROFEN 10% KIT #1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 112.

Decision rationale: The request for Enovarx-ibuprofen 10% kit quantity: 1 is non-certified. The injured worker complained of chronic low back pain with left lower extremity radiation, left shoulder pain, and left knee pain. The treating physician's rationale for Enovarx-ibuprofen 10% kit is due to the injured worker's GI upset from oral NSAIDs. The CA MTUS guidelines for topical non-steroidal anti-inflammatory drugs (NSAIDs) state that there is little evidence to utilize topical NSAIDs for the treatment of osteoarthritis of the spine, hip or shoulder. Also, the treatment on neuropathic pain is not recommended. Enovarx-ibuprofen is a product of Enovachem manufacturing. It is noted that Enovarx-ibuprofen is available in 60 g and 120 g. There is a lack of clinical documentation indicating the injured worker has used a proton pump inhibitor to decrease NSAID GI upset. The treating physician did not specify the requesting formulaic distribution of either 60 g or 120 g. Furthermore, the requesting provider did not specify the utilization frequency or the location of application of the medication being requested. The guidelines do not recommend topical NSAIDs for the treatment of osteoarthritis in the spine, hip, or shoulders. Therefore, the request is non-certified.

