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| Case Number: | CM14-0026365 | | |
| Date Assigned: | 06/13/2014 | Date of Injury: | 06/14/2009 |
| Decision Date: | 07/22/2014 | UR Denial Date: | 02/10/2014 |
| Priority: | Standard | Application Received: | 03/03/2014 |

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 Orthopedic Surgery 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 injured worker is a 24 year-old female injured on 6/14/2009. The mechanism of injury is noted as a trip and fall. The most recent progress note, dated 1/14/2014 indicates that there are ongoing complaints of neck pain, left shoulder pain, left wrist pain, lower back pain, right knee pain, left knee pain, she also complains of tingling pain on the left shoulder radiating down to the hand with numbness. The physical examination demonstrated decreased grip strength on the left, cervical spine: tenderness and spasm to cervical paraspinal musculature bilaterally. Range of motion: flexion 45, extension 30, rotation right/left 45, lateral flexion right/left 30, left rotation is limited due to localize pain. Shoulder: tenderness to palpation to the left rotator cuff muscles. Range of motion: within normal limits on the right, left = flexion 180, extension 30, abduction 90, adduction 30, internal rotation 60, external rotation 80. Positive empty can-supraspinatus test on the left. Wrist/hand: range of motion of the left wrist is limited due to pain. Positive Phalen's on the left. Tinnel's negative bilaterally. Lumbar spine: tenderness and spasm to paraspinal muscles bilaterally. Range of motion limited due to pain flexion 45, extension 5, lateral flexion to the right 18 left 20. Knee: range of motion on the left side limited due to pain 0 through 110. Diagnostic imaging studies include an MRI of the lumbar spine from 7/14/2009 which reveals L4-L5 2 mm annular broad-based disc bulge is seen flattening and impressing upon anterior portion of the thecal sac with minimal left and no significant right neural foraminal stenosis. MRI of the cervical spine performed on the same date reveals slight loss of disc height at C4-C5 and C5-C6 with straightening of the normal cervical spine lordosis. C4-C5 and C5-C6 left greater than right paracentral 2.5 mm annular broad-based disc bulges with flattening and impressing upon anterior portion of the thecal sac with decreased anterior subarachnoid space and mild left more than right neural foraminal stenosis. MRI of the left wrist was performed on 7/17/2009 which revealed slight fluid seen in the radio carpal and radial ulnar joint next to the

triangular fibrocartilage so partial tear cannot be excluded. No full thickness tear is seen. Previous treatment includes bilateral knee surgery, medications to include Relafen, Flexeril. A request had been made for tramadol er 150 mg #30, topical compounded tghot cream #180 grams, topical compound flurflex cream #180 grams, lidoderm patches 5% #30, and a mri of the left wrist which was not certified in the pre-authorization process on 2/10/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL ER 150 MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria For Use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 82, 113 of 127.

Decision rationale: Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. It is not recommended as a first-line therapy. Opioid analgesics and Tramadol have been suggested as a second-line treatment (alone or in combination with first-line drugs). A recent consensus guideline stated that opioids could be considered first-line therapy for the following circumstances: (1) prompt pain relief while titrating a first-line drug; (2) treatment of episodic exacerbations of severe pain; and (3) treatment of neuropathic cancer pain. (Dworkin, 2007). According to the medical documentation provided on July 9, 2014, a modified decision for the approval of this medication authorize one refill decision date was 2/10/2014. No other refills were authorized. With this information, the request for Tramadol ER 150 mg #30 is not medically necessary.

TOPICAL COMPOUNDED TGHOT CREAM #180 GRAMS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that topical analgesics are "largely experimental" and "any compound product that contains at least one drug (or drug class) that is not recommended, is not recommended". The guidelines indicate Gabapentin is not recommended for topical application. Additionally, the guidelines recommend the use of Capsaicin only as an option for patients who are intolerant of other treatments and there is no indication that an increase over a 0.025% formulation would be effective. There is no documentation in the records submitted indicating the claimant was intolerant of other treatments. The request for topical TGHot is not in accordance with the Chronic Pain Medical Treatment Guidelines. Therefore, the request for TGHot Cream#180gm is not medically necessary.

TOPICAL COMPOUND FLURFLEX CREAM #180 GRAMS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): Page 111-113 of 127.

Decision rationale: Chronic Pain Guidelines state that topical analgesics are "largely experimental" and "any compound product that contains at least one drug (or drug class) that is not recommended is not recommended". The guidelines note there is little evidence to support the use of topical NSAIDs (Flurbiprofen) for treatment of osteoarthritis of the spine, hip or shoulder and there is no evidence to support the use for neuropathic pain. Additionally, the guidelines state there is no evidence to support the use of topical Cyclobenzaprine (a muscle relaxant). The guidelines do not support the use of Flurbiprofen or Cyclobenzaprine in a topical formulation. Therefore, the request for FluriFlex Cream #180gm is not medically necessary.

LIDODERM PATCHES 5% #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 56 of 127.

Decision rationale: The Chronic Pain Medical Treatment Guidelines support the use of topical lidocaine for individuals with neuropathic pain that have failed treatment with first-line therapy including antidepressants or anti-epilepsy medications. Based on the clinical documentation provided, the injured worker has not failed first-line therapy utilizing an antidepressant or anti-episode epilepsy medication. As such, the request of Lidoderm Patches 5% #30 is considered not medically necessary.

MRI OF THE LEFT WRIST: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist & Hand (Acute& Chronic), Indications for Imaging-MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

Decision rationale: After reviewing the medical documentation, it shows this claimant having chronic left wrist pain dating back to work related injury in 2009. After reviewing recent reports from treating physician the physical exam shows wrist/hand: range of motion of the left wrist is limited due to pain. Positive Phalen's on the left. Tinnel's negative bilaterally. No recent

diagnostic studies of been taken i.e. x-rays. The MRI the left wrist is requested in order to assess the possibility of soft tissue trauma cartilage damage, or tendon/ligament tears. Based on the associated physical examination findings and objective clinical documentation in the notes provided the request for MRI of the left wrist is deemed not medically necessary and appropriate.