

Case Number:	CM14-0035249		
Date Assigned:	07/23/2014	Date of Injury:	07/15/2006
Decision Date:	09/09/2014	UR Denial Date:	03/03/2014
Priority:	Standard	Application Received:	03/21/2014

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 & Rehabilitation, has a subspecialty in Interventional Spine 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 50-year-old female with a date of injury of 07/15/2006. The listed diagnoses per Dr. [REDACTED] are: 1. Resolved right wrist strain. 2. Lumbar spine discopathy. 3. Right knee chondromalacia with slight lateralization of the patella. 4. Status post right shoulder surgery, 2008. 5. Status post right arthroscopy, 2012. 6. Cervical sprain/strain. According to progress report, 01/20/2014, by Dr. [REDACTED], the patient presents with ongoing pain to the lower back and right shoulder. Patient states she has aching and burning pain to her low back which she rates as 5/10 to 8/10 and pain in her shoulder rated at 5/10 with pins and needle sensation. Patient also reports fatigue and trouble sleeping. Examination of the shoulder revealed tenderness in the acromioclavicular joint and positive impingement sign. There is pain with range of motion. Examination of the lumbar spine revealed midline tenderness and spasm over the lumbar area. Straight leg raise is positive bilaterally at 90 degrees. The patient was given 2 intramuscular injections of vitamin B12 complex and Toradol injection. Patient was also given a refill of medications including tizanidine 4 mg, tramadol 50 mg, hydrocodone 10/325 mg, amitramadol-DM ultra cream, gabapentin/Ketaprofen/lidocaine topical cream. Utilization review denied the request on 03/03/2014. There are no urine drug screens provided in the medical file.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 4mg, take one by mouth every 12 hours as needed, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for Pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY/ANTISPASMODIC DRUGS: (MTUS pg 66) Page(s): 66.

Decision rationale: This patient presents with ongoing pain to the lower back and right shoulder. The provider is requesting a refill of Tizanidine 4 mg #120 for spasm. The MTUS Guidelines, page 66 allows for the use of Zanaflex (Tizanidine) for low back pain, myofascial pain, and fibromyalgia. Given the patient's low back pain, Tizanidine may be indicated. However, the provider has been giving refills of this medication since September 2013 without discussing its efficacy. According to MTUS page 60 it requires documentation of pain assessment and functional changes when medications are used for chronic pain therefore the request for Tizanidine 4mg #120 is not medically necessary.

Tramadol 50mg, #60, take every 4-6 hours as needed: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines on Long-term Opioid use, page 88-89 Page(s): 88-89.

Decision rationale: The provider is requesting a refill of Tramadol 50 mg #60 to be taken every 4 to 6 hours as needed. Provider states the medication is helping relieve the patient's moderate to severe pain. Page 78 of MTUS requires pain assessment that should include, current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Furthermore, The 4 A's for ongoing monitoring are required that include analgesia, activities of daily living (ADL's), adverse side effects and aberrant drug-seeking behavior. This patient has been taking Tramadol since at least 08/07/2013. Progress reports from 08/07/2013 to 01/20/2014 are reviewed. The provider states medications are helping in providing relief with the patient's moderate to severe pain, but does not provide specific functional improvement with taking medications. Numerical scales are used to rate pain but they are not correlated with medication intake. Given the lack sufficient documentation for chronic opioid use the request for Tramadol 50mg #60 is not medically necessary.

Hydrocodone/APAP 10/325mg, #60 take 1 by mouth every 6-8 hours as needed: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines on Long-term Opioid use, page 88-89 Page(s): 88-89.

Decision rationale: The provider is requesting a refill for hydrocodone 10/325 mg #60 to be taken every 6 to 8 hours as needed for pain. Page 78 of MTUS requires pain assessment that should include, current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Furthermore, The 4 A's for ongoing monitoring are required that include analgesia, ADL's, adverse side effects and aberrant drug-seeking behavior. Review of the medical file indicates the patient has been taking Hydrocodone since at least 09/12/2013. The provider states this medication helps provide relief with patient's moderate to severe pain, and based on long-term assessment but the provider believes the patient is a candidate for ongoing use of Hydrocodone. However, the progress reports from 09/12/2013 to 01/20/2014 do not provide any specifics regarding analgesia or ADL's as required by MTUS. No numerical scales are used as required by MTUS 98 regarding outcome measures. Given the lack of sufficient documentation, the patient should slowly be weaned off of Hydrocodone therefore the request for Hydrocodone/APAP 10/325mg #60 is not medically necessary.

Amitramadol-DM Ultracream 4/20/10% 240gm, to apply a thin layer to affected area 2-3 times daily: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines The MTUS has the following regarding topical creams(p111, chronic pain section):Topical Analgesics Page(s): 111.

Decision rationale: The medical provider is requesting a topical cream, Amitramadol-DM ultra cream to be applied to affected area 2 to 3 times daily. Treater states these transdermals are prescribed for symptomatic relief. The MTUS has the following regarding topical creams; topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety. The guidelines further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." In this case, Tramadol is not tested for transdermal use with any efficacy. Furthermore, the providing doctor does not discuss why the patient it utilizing both oral Tramadol as well as topical Tramadol. The recommended compound topical cream is not medically necessary.

Gabapentin/Ketoprofen/Lidocaine 6/20/6.15% 240gm cream for pain to apply for a thin layer to affected area twice daily as dosed (6 hours apart, then withhold for 12 hours): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines The MTUS has the following regarding topical creams(p111, chronic pain section) Page(s): 111.

Decision rationale: The providing doctor is requesting a compound topical cream for patient's symptomatic pain relief. The compound topical cream includes gabapentin, ketoprofen, and lidocaine. The MTUS Guidelines has the following regarding topical creams; topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety. MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." The MTUS Guidelines page 112 supports the use of topical NSAIDs for peripheral joint arthritis or tendinitis which this patient has. However, non-FDA approved agents like Ketaprofen is not recommended for any topical use. The guidelines also state this agent is not currently FDA approved for topical application. It has an extremely high incident of photo contact dermatitis. Furthermore, Gabapentin is not recommended as a topical formulation and is not medically necessary.

Retrospective intramuscular injection of Vitamin B-12 complex: 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, Vitamin B.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the Non-MTUS, AETNA Clinical Policy Bulletin: Vitamin B-12.

Decision rationale: The request is for retrospective request of intramuscular injection of vitamin B12 complex. The ACOEM, MTUS ODG guidelines do not discuss Vitamin injections. Aetna guidelines discuss Vitamin B-12 therapy for medical conditions and considers it for Anemia, GI disorders, Neuropathy due to malnutrition/alcoholism/pernicious anemia/posterolateral sclerosis. Aetna considers Vitamin B-12 injections experimental and investigational for all other indications. Based on current evidence it does not appear that Vitamin B12 is supported for chronic pain therefore the request for Retrospective intramuscular injection of Viatmin B-12 Complex is not medically necessary.

Retrospective intramuscular injection of Toradol: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page 72, MTUS Page(s): 72.

Decision rationale: The request is for retrospective request of intramuscular injection of Toradol. The MTUS Guidelines page 70 under NSAIDs, specific drug list and adverse effects states, recommended with cautions below: Disease-state warnings for all NSAIDs, all NSAIDS have US boxed warnings for associated risk of adverse cardiovascular events including MI, stroke, and new onset or worsening of pre-existing hypertension. Boxed warning for Ketorolac 10 mg states that medication is not indicated for minor or chronic painful conditions. The requested Toradol injection is not medically necessary and appropriate.