

Case Number:	CM14-0204013		
Date Assigned:	12/16/2014	Date of Injury:	06/23/2014
Decision Date:	02/05/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/05/2014

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 Occupational 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:

Patient is a 20 year-old female with date of injury 06/23/2014. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 11/18/2014, lists subjective complaints as pain in the neck, mid, and low back. Objective findings: Cervical MRI on 08/28/2014 was consistent with annular tears at C4-5 and C5-6. Lumbar MRI on 08/28/2014 was normal. Physical examination revealed no neuromuscular deficits in the limbs. Tenderness to palpation of the cervical and thoracic paraspinals. No other physical examination findings were documented by the requesting physician. Diagnosis: 1. Cervical strain/ annular tear 2. Lumbar strain 3. Thoracic strain vs. disc injury. The medical records supplied for review document that the patient was first prescribed the following medication on 11/18/2014. The requesting provider did not provide SIGs. Medication: 1. Tramadol 50mg, #902. Mobic 7.5mg, #603. Voltaren 1% Gel, 100g4. Flector 1% Patches, #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg #90: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. There is no documentation supporting the continued long-term use of opioids. Therefore, the request for 90 tablets of Tramadol 50mg is not medically necessary.

Mobic 7.5mg #60 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73.

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. Therefore, the request for 60 tablets of Mobic 7.5mg with 3 refills is not medically necessary.

100 tubes (100g) 1% of Voltaren gel with 3 refills: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Voltaren® Gel (diclofenac).

Decision rationale: According to the Official Disability Guidelines, Voltaren gel is not recommended as a first as a first-line treatment, and is recommended only for osteoarthritis after failure of oral NSAIDs, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations. Documentation in the medical record does not meet guideline criteria. Therefore, the request for 100 tubes (100g) 1% of Voltaren gel with 3 refills is not medically necessary.

Flector 1% patch #30 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 111-112.

Decision rationale: According to the MTUS, Flector patches are indicated for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Therefore, the request for 30 patches of Flector 1% with 3 refills is not medically necessary.