

Case Number:	CM15-0001334		
Date Assigned:	01/12/2015	Date of Injury:	06/21/2012
Decision Date:	03/06/2015	UR Denial Date:	12/05/2014
Priority:	Standard	Application Received:	01/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Emergency Medicine

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 56-year-old male, who sustained an industrial injury on 06/21/2012. He has reported left shoulder pain, headache, upper back pain, back pain, and left wrist pain. The diagnoses have included shoulder sprain/strain and rule out internal derangement of the left shoulder. Treatment to date has included physical therapy, and oral pain medications. Currently, the injured worker complains of intermittent pain in his left shoulder radiating to his left hand and left finger. He rated his pain 4-5 out of 10. He also complains of numbness and tingling in the upper extremity. The injured worker stated that physical therapy was helpful with the range of motion. The objective findings included tenderness upon palpation of the left shoulder; moderate tenderness at the acromioclavicular joint, anterior labrum, supraspinatus, infraspinatus, bicipital group and upper trapezius on the left; and decreased range of motion of the left shoulder. The treating physician recommended Tramadol and Soma for the treatment of pain. On 12/05/2014, Utilization Review (UR) modified the request for Tramadol 50mg #120, with four refills and Soma 300mg #120, with four refills. The UR physician noted that Tramadol is recommended for moderate to severe pain, without refill for medication monitoring; and refills for Soma are not appropriate due to guideline recommendations of short-term use. The UR physician provided certification for Tramadol 50mg #120, without refills and Soma 350mg #60, without refills. The MTUS Chronic Pain Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50 mg, 120 count with four refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76.

Decision rationale: Tramadol is a direct Mu-agonist, an opioid-like medication. It is noted that patient has chronically been on this pain medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation fails all criteria. There is no appropriate documentation of any objective improvement in pain or functional benefit as defined by MTUS guidelines. There is also no appropriate documentation of abuse or side effect monitoring. The number of tablets and refills prescribed is inappropriate and would give patient almost 5months of unsupervised use of this medication failing MTUS guideline recommendation of appropriate monitoring. Tramadol is not medically necessary.

Some 350 mg, 120 count with four refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol(Soma) Page(s): 29.

Decision rationale: As per MTUS Chronic pain guidelines, Carisoprodol or Soma is a muscle relaxant and is not recommended. There is a high risk of side effects and can lead to dependency requiring weaning. Carisoprodol has a high risk of abuse and can lead to symptoms similar to intoxication and euphoria. The poor documentation does not provide any rational justification for continuing this medically inappropriate medication. The number of tablets and refills prescribed is completely inappropriate and would give the patient almost 6months of unmonitored use of a potentially addictive, dangerous and not-recommended medication. Soma is not medically necessary.