

Case Number:	CM15-0008658		
Date Assigned:	01/26/2015	Date of Injury:	04/30/2014
Decision Date:	04/10/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/15/2015

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: Physical Medicine & Rehabilitation, Pain Management

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 male patient, who sustained an industrial injury on 04/30/2014. A QME visit dated 12/09/2014 reported persistent complaint of pain in the left shoulder and left knee. The worker is noted being taking out of work on temporary disability until the next office visit secondary to place of employment not honoring restrictions and patient with persistent pain. He has a history for undergoing 12 therapy sessions in the past treating shoulder, nothing recent. He is noted taking prescribed medications with note that they make him drowsy. Objective findings showed left shoulder abduction is 90 degrees with discomfort. His knee has full extension and flexion at about 110 degrees. There is noted pain across the joint line medially and laterally. He is diagnosed with left shoulder impingement, rotator cuff strain, bicipital tendonitis, and AC joint inflammation; along with left knee internal derangement. The treatment plan included cortisone injection to left shoulder and knee, pending. On 12/31/2014 Utilization Review non-certified a request for the following medications; Nalfon, Flexiril and Tramadol, noting, the CA MTUS Chronic Pain, Muscle relaxants, Opioids and NSAIDS were cited. The injured worker submitted an application for independent medical review on 01/15/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol ER 150mg 1 tab OD #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Opioids, specific drug list Page(s): 76-78, 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-80.

Decision rationale: Regarding the request for tramadol ER, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested tramadol ER is not medically necessary.

Nalfon 400mg 1 tab, two (2) times per day: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68, 71.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

Decision rationale: Regarding the request for Nalfon, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that the medication is providing any specific analgesic benefits (in terms of percent pain reduction or reduction in numeric rating scale) or any objective functional improvement. In the absence of such documentation, the currently requested Nalfon is not medically necessary.

Flexeril 7.5mg 1 tab two (2) times per day #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril); Muscle relaxants (for pain) Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-66.

Decision rationale: Regarding the request for Flexeril, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation

available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Flexeril is not medically necessary.