

Case Number:	CM15-0105773		
Date Assigned:	06/10/2015	Date of Injury:	07/09/2014
Decision Date:	07/14/2015	UR Denial Date:	04/30/2015
Priority:	Standard	Application Received:	06/02/2015

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: New York

Certification(s)/Specialty: Anesthesiology

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 45 year old male, who sustained an industrial injury on 07/09/2014. According to a Doctor's First Report of Occupational Injury or Illness dated 04/17/2015, the injured worker reported that he was walking into the warehouse to pick up a package when he noticed that a forklift operator was having difficulty coming out of the warehouse. He moved to the side to make way for the forklift when one of the metal racks fell off from it. He immediately put out his left upper extremity to prevent it from hitting his face but because of the weight, he was pushed down to the ground causing him to fall face forward. He fell in an awkward position causing him to feel immediate pain in his neck, back and left shoulder. Treatment to date has included physical therapy and medications. Diagnoses included cervical musculoligamentous strain/sprain with radiculitis, rule out cervical spine discogenic disease, thoracic musculoligamentous strain/sprain, lumbosacral musculoligamentous strain/sprain, history of lumbosacral spine discogenic disease per patient, left shoulder strain/sprain, left shoulder tendinitis and left shoulder impingement syndrome. Prescriptions were given for Elavil, Tramadol, Cyclobenzaprine, Terocin patches and a TENS unit. A functional capacity evaluation was on hold. Further treatment required included physical therapy evaluation and treatment for the cervical/thoracic/lumbar spine and left shoulder, 2 times a week for 6 weeks. Currently under review is the request for one prescription of Tramadol 50mg #60, one prescription of Cyclobenzaprine 7.5mg #90, one prescription of Terocin patch #60, one TENS unit and 12 physical therapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) prescription of Tramadol 50mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the California MTUS, Tramadol (Ultram) is a synthetic opioid, which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, this patient has been maintained on Norco. There has been no documentation of the medication's analgesic effectiveness or functional improvement, and no clear documentation that the patient has responded to ongoing opioid therapy. Switching to Tramadol would not be expected to result in any different outcome for the patient. Medical necessity for the requested medication has not been established. The requested treatment with Tramadol is not medically necessary.

One (1) prescription of Cyclobenzaprine 7.5mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, the requested quantity exceeds the amount that would be used in the recommended 2-3 week time period, per the MTUS guidelines. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

One (1) prescription of Terocin patch #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: There is no documentation provided necessitating the use of the requested topical medication, Terocin. According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating Terocin. This medication contains methyl salicylate, capsaicin, menthol, and lidocaine. MTUS states that capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There is no documentation of intolerance to other previous medications. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.

One (1) TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-121.

Decision rationale: According to the MTUS guidelines, the TENS unit is not recommended as a primary treatment modality. A one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for conditions such as, neuropathic pain, phantom limb pain, complex regional pain syndrome (CRPS), spasticity or multiple sclerosis. In this case, there have been no other first-line therapies such as tricyclic anti-depressants. In addition, there is no specific treatment plan which outlines the short-term or long-term goals for the TENS unit. Medical necessity for the requested item has not been established. The requested TENS unit is not medically necessary.

Twelve (12) physical therapy sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. According to the records, this patient had previous therapy but there is no documentation indicating that he had a defined functional improvement in his condition. There is no specific indication for the additional 12 PT sessions. Medical necessity for the additional PT visits requested has not been established. The requested services are not medically necessary.