

Case Number:	CM15-0134952		
Date Assigned:	07/23/2015	Date of Injury:	02/25/2014
Decision Date:	08/19/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	07/13/2015

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: Utah, Arkansas

Certification(s)/Specialty: Family Practice, Sports 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 2/25/14. Initial complaints were of his left shoulder, left biceps, right hand, low back, legs, right knee and quadriceps. The injured worker was diagnosed as having cervical spine degenerative disc disease C5-6 with right-sided stenosis; left shoulder rotator cuff tear (status post-surgical repair); left shoulder with persistent impingement syndrome; left elbow biceps tendon rupture with residuals; right ring trigger finger, (status post-surgical release); right knee quadriceps tendon rupture (status post-surgical repair); right knee (status post arthroscopic chondroplasty/debridement of lateral meniscus); hypertension; sleep disorder; stress, anxiety, depression; lumbar disc degeneration; chronic pain other; lumbar facet arthropathy. Treatment to date has included physical therapy; right knee brace; lumbar epidural steroid injection; medications. Diagnostics studies included MRI cervical spine (2/18/15); MRI left shoulder dated (2/18/15). Currently, the PR-2 notes dated 6/8/15 indicated the injured worker is in the office for a follow-up and re-examination. He complains of neck pain that radiates down and aggravated by activity and walking. He also has low back pain that is constant and radiates down the bilateral lower extremities. It is accompanied by numbness constantly of the bilateral lower extremities to the level of the hips to the thighs to the knee for the calves and then to the feet and toes. The pain is described as stabbing and moderate to severe. He reports a moderate difficulty in sleep. His lower extremity pain is in the right knee and quadriceps and occurs constantly and is described as stabbing and severe with numbness and swelling. It is rated at 8/10 with medications and unchanged since last visit. He is a status post lumbar epidural steroid injection bilateral L5 on

5/1/15 with 50-80% overall improvement. He is scheduled for a cervical epidural steroid injection on 7/10/15. The injured worker is scheduled for left shoulder surgery on 8/10/15. A MRI of the cervical spine dated 2/18/15 impression reports spinal stenosis at all cervical levels that are mild to moderate with neural foraminal narrowing and severe bilateral neural foraminal narrowing at C5-6. A MRI of the left shoulder dated 2/18/15 impression shows interval rotator cuff surgery with no evidence of recurrent rotator cuff tear. The labrum cannot be adequately evaluated on the current exam due to open MRI nature of exam and absence of intra-articular contrast. There is a small paralabral cyst seen posteroinferiorly which was also present on prior exam. No extension of contrast was seen into the labrum on prior exam but the findings may be related to small tear, with scarring. There has been interval tear of the superior labrum and attachment of the tendon of the long head of the biceps. The MRI shows an interval acromioplasty with no evidence of impingement; interval possible tenodesis of the biceps. The provider documents a physical examination that notes spinal vertebral tenderness and limited range of motion due to pain. The provider is requesting authorization of Ibuprofen 800mg #90; Tramadol 50mg #60 and Flector patches 1.3% #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 800mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, and cardiovascular risks.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) pages 66-73.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Ibuprofen. MTUS guidelines state that these medications are recommended at the lowest dose for the shortest period in patient with moderate to severe pain. There is lack of specific documentation of functional improvement, while on this medication. As well as there is noted frequent gastrointestinal upset. According to the clinical documentation provided and current MTUS guidelines; Ibuprofen is not indicated a medical necessity to the patient at this time. Therefore, the request is not medically necessary.

Tramadol 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 113, 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, page(s) 75-79.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The MTUS indicates that ongoing management of opioids includes documentation of prescriptions given from a single practitioner, prescriptions

from a single pharmacy and the lowest dose should be used to improve function. There should also be an ongoing review of the 4 As, including analgesia, activities of daily living, adverse side effects, and aberrant drug behaviors. There is no clear functional gain that has been documented with this medication. Guidelines state that the discontinuation of opioid medication is recommended if there is no overall improvement in function. According to the clinical documentation provided and current MTUS guidelines; Tramadol, as written above, is not indicated a medical necessity to the patient at this time. Therefore, the request is not medically necessary.

Flector patches 1.3% #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel, page 112. Diclofenac.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Flector Patch. MTUS guidelines state the following: Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. According to the clinical documentation provided and current MTUS guidelines; Flector Patch is not indicated as a medical necessity to the patient at this time. Therefore, the request is not medically necessary.