

Case Number:	CM15-0197153		
Date Assigned:	10/12/2015	Date of Injury:	05/06/2013
Decision Date:	11/19/2015	UR Denial Date:	09/28/2015
Priority:	Standard	Application Received:	10/07/2015

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: Montana

Certification(s)/Specialty: Preventive Medicine, Occupational 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 48 year old female dental assistant, who sustained an industrial injury on 5-6-13. The injured worker was diagnosed as having carpal tunnel syndrome, unspecified disorder bursae tendons shoulder, cervical spondylosis without myelopathy, cervical strain and repetitive strain injury. Treatment to date has included physical therapy, acupuncture TENS, splinting and medications. Diagnostics studies included EMG-NCV study bilateral upper extremities (3-19-15). Currently, the PR-2 notes dated 9-18-15 indicated the injured worker presented to the office as a follow-up on her left shoulder and bilateral arm-wrist and hand complaints. The provider documents "She is on Lyrica and has noticed it has caused cognitive effects during the day. She's been on this for over a month and the symptoms have not resolved. She was not able to take more than one a bedtime. Patient continues to work with her restrictions. She saw a surgeon who recommended bilateral carpal tunnel release. This was denied, appealed and still denied. Denial was based on the fact that she did not have cortical steroid injections into the wrist to be used as a test prior to the surgery despite the fact that she does have positive nerve test for carpal tunnel. She is wearing her splints in the evening and occasionally at work during the day. The orthopedist recommended surgery to the wrists first; he felt her left shoulder symptoms would improve following the carpal tunnel surgery. She continues to be symptomatic." On physical examination, the provider documents "Positive Tinel's at the wrists bilaterally. Patient is unable to tolerate the Phalen's test as just putting her hands-wrists into that position causes extreme discomfort. Numbness tingling and decreased sensation into the index and middle finger on the left hand; grip strength on the left 20 pounds,

right 22 pounds. Deep tendon reflexes 2 over 4 in upper extremities, symmetric. Tenderness with palpation over the distal supraspinatus and subacromial area. She does have mildly restricted range of motion of the left shoulder, pain with end range internal motion. Tenderness in the left mid to lower paracervical areas extending long the trapezius. Pain aggravated with extension and rotation, these maneuvers cause pain on the contralateral side mid to lower paracervical areas. Spurling's test is negative." An EMG-NCV study of the bilateral upper extremities reveals "1) There is electrodiagnostic evidence for moderate to severe right slightly worse than left carpal tunnel syndrome. 2) There is no electrodiagnostic evidence for a) bilateral ulnar or radial focal neuropathy. b) bilateral cervical radiculopathy." His treatment plan is requesting "authorization for a corticosteroid injection with ultrasound guidance to the left wrist to be used as a test for this patient showing signs and symptoms consistent with carpal tunnel syndrome." He is also requesting medications and to continue work restrictions and the splint. PR-2 notes dated back as far as 3-19-115 indicates the injured worker has been prescribed Ultracet. A Request for Authorization is dated 10-5-15. A Utilization Review letter is dated 9-28-15 and modified the certification for Ultracet 37.5mg-325mg tablet, 1 tablet by mouth four times daily #120 with 2 refills to authorize the request with no refills "for the purpose of weaning to discontinue". A request for authorization has been received for Ultracet 37.5mg-325mg tablet, 1 tablet by mouth four times daily #120 with 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultracet 37.5mg-325mg tablet, 1 tablet by mouth four times daily #120 with 2 refills:
Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter (Online Version), Tramadol/Acetaminophen (Ultracet); MedicineNet.com, Ultracet.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, criteria for use, Opioids for chronic pain, Opioids for osteoarthritis, Opioids, dealing with misuse & addiction, Opioids, long-term assessment, Opioids, pain treatment agreement, Opioids, specific drug list.

Decision rationale: The MTUS notes that Ultracet (tramadol and acetaminophen) is a central acting opioid analgesic that may be used to treat chronic pain and neuropathic pain. The MTUS states that opioids are not recommended as first line therapy for neuropathic pain. Opioids are suggested for neuropathic pain that has not responded to first line recommendations including antidepressants and anticonvulsants. The MTUS states that reasonable alternatives to opioid use should be attempted. There should be a trial of non-opioid analgesics. When subjective complaints do not correlate with clinical studies a second opinion with a pain specialist and a psychological assessment should be obtained. The lowest possible dose should be prescribed to improve pain and function. Ongoing use of tramadol requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: the least reported pain over the period since the last assessment; average pain; intensity

of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Opioid use for chronic pain appears to be effective for short-term pain relief but long-term benefit is unclear. Tramadol specifically is found to have a small benefit (12% decrease in pain intensity baseline) for up to 3 months. No long-term studies allow for recommended use beyond 3 months. In this case the medical records do not document any specific functional improvement or quantified decreased in pain related to use of Ultracet. There is no pain assessment as described above. The Ultracet has been used since 2-14-15 and the current request is for 3 additional months. This is not consistent with the MTUS guidelines, with use not recommended beyond 3 months. The request for Ultracet 37.5/325 1 tab 4 times daily #120 with 2 refills is not medically necessary.