

Case Number:	CM15-0199857		
Date Assigned:	10/15/2015	Date of Injury:	03/26/1998
Decision Date:	11/25/2015	UR Denial Date:	09/18/2015
Priority:	Standard	Application Received:	10/12/2015

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 Jersey

Certification(s)/Specialty: Family Practice

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 63 year old, female who sustained a work related injury on 3-26-99. A review of the medical records shows she is being treated for right shoulder, right hand and low back pain. In the progress notes dated 6-19-15, 8-7-15, and 9-4-15, the injured worker reports constant right hand pain which she rates a 6-7 out of 10. She reports constant low back pain which she rates 7 out of 10. She reports aching pain in her right shoulder which she rates 9 out of 10. On physical exam dated 9-4-10, she has tenderness in the right acromioclavicular joint. She has decreased range of motion in right shoulder. She has crepitus with motion of right shoulder. She has abnormal skin color and cool temperature with right hand. She has some pain with range of motion in right hand. She has pain in lower lumbar midline and paraspinal muscles. She has pain and tenderness in sacroiliac area. She has some muscle with forward flexion in lumbar spine area. Treatments have included pain injections and right carpal tunnel surgery. Current medications include Ambien, Xanax, and hypertension meds. She is temporarily totally disabled. The treatment plan includes requests for physical therapy and acupuncture, for Ultram and medicated topical cream and a Toradol injection was given at this visit. The Request for Authorizations dated 9-4-15 has requests for a retrospective Toradol injection for this date and for Ultram and medicated cream. In the Utilization Review dated 9-18-15, the requested treatments of a Toradol injection, Ultram 50mg. #60 and Flurbiprofen 10%-Gabapentin 10%-Capsaicin 0.25%-Camphor 2%-Menthol 2% cream are not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Intramuscular Injection of Toradol DOS 9/4/15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Ketorolac.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, specific drug list & adverse effects. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Ketorolac.

Decision rationale: The MTUS Guidelines state that NSAIDs (non-steroidal anti-inflammatory drugs) may be recommended for osteoarthritis as long as the lowest dose and shortest period is used. The MTUS also recommends NSAIDs for short-term symptomatic use in the setting of back pain if the patient is experiencing an acute exacerbation of chronic back pain if acetaminophen is not appropriate. NSAIDs are not recommended for neuropathic pain, long-term chronic pain, and relatively contraindicated in those patients with cardiovascular disease, hypertension, kidney disease, and those at risk for gastrointestinal bleeding. Ketorolac (Toradol), is an NSAID typically use in injectable form for acute pain, and is not indicated for minor or chronic painful conditions. The oral form is only recommended to be used for short durations (up to 5 days) in management of moderately severe acute pain, and should not be given as an initial dose, but only as a continuation after an intravenous or intramuscular dose. In the case of this worker, a Toradol injection was recommended and given on 9/4/15. However, upon review of the progress note from that visit, there was insufficient evidence to suggest her pain was an acute flare-up, but rather her chronic pain. The request is not medically necessary.

Ultram 50 MG #60 with 1 Refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, long-term assessment.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that opioids may be considered for moderate to severe chronic pain as a secondary treatment, but require that for continued opioid use, there is to be ongoing review and documentation of pain relief, functional status, appropriate medication use with implementation of a signed opioid contract, drug screening (when appropriate), review of non-opioid means of pain control, using the lowest possible dose, making sure prescriptions are from a single practitioner and pharmacy, and side effects, as well as consultation with pain specialist if after 3 months unsuccessful with opioid use, all in order to improve function as criteria necessary to support the medical necessity of opioids. Long-term use and continuation of opioids requires this comprehensive review with documentation to justify continuation. In the case of this worker, Ultram was seen as being

prescribed and used on a chronic basis based on the notes provided for review. However, there was insufficient record seen in recent notes regarding how effective this medication was at reducing pain and improving function, which would be required in order to justify this request. Therefore, Ultram is not medically necessary at this time. Weaning may be indicated.

Flurbiprofen/Gabapentin/Capsaicin/Camphor/Menthol 10/10/.025/2/2 Percent 180 Gram Cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The MTUS Chronic Pain Guidelines state that topical analgesics are generally considered experimental as they have few controlled trials to determine efficacy and safety currently. Topical NSAIDs, specifically, have some data to suggest it is helpful for osteoarthritis and tendinitis for at least short periods of time, but there are no long-term studies to help us know if they are appropriate for treating chronic musculoskeletal pain. Topical gabapentin is specifically listed as non-recommended by the MTUS Chronic Pain Treatment Guidelines due to lack of supportive data for regular use in chronic pain. The Guidelines also state that if there is at least one ingredient in a combination topical analgesic medication which is non-recommended then the entire product should be considered as such. In the case of this worker, the provider recommended the worker take Flurbiprofen / Gabapentin / Capsaicin / Camphor / Menthol 10/10/.025/2/2 Percent 180 Gram Cream. In the case of this worker, there was insufficient record seen from recent notes on how effective this topical combination analgesic product, which was used leading up to this request for renewal. Regardless, due to this medication having gabapentin, which is not recommended for topical use, this request is not medically necessary.