

Case Number:	CM15-0040929		
Date Assigned:	03/11/2015	Date of Injury:	04/11/2011
Decision Date:	04/21/2015	UR Denial Date:	02/06/2015
Priority:	Standard	Application Received:	03/04/2015

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

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 April 11, 2011. The injured worker was diagnosed as having depression, bursa of the shoulder region and chronic pain syndrome. Treatment to date has included medication, lumbar laminectomy, depression, bursa of the shoulder region and chronic pain syndrome. Currently, the injured worker's main concern is that the medications recommended are denied by the insurance carrier. He complains of his pain has worsened since he has not been able to use his medications. He reports anger, depression and frustration because he is experiencing pain again. He reports that his sleep is significantly worse since the discontinuation of Cymbalta. The medications allowed him to function without pain. On examination he is ambulatory and has negative bilateral seated straight leg raises. He reported pain to adduction of the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, long-term assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Long-term opioids use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: This patient has a date of injury of 04/11/11 and presents with neck, shoulder and low back pain. The back pain radiates into the buttocks. The Request for Authorization is not provided in the medical file. The current request is for Tramadol 50mg #60 with 2 Refills. For chronic opiate use, the MTUS guidelines pages 88 and 89 states, "Pain should be assessed at each visit and function should be measured at 6-month intervals using a numerical scale or validated instrument." The MTUS page 78 also requires documentation of the 4 A's, which includes analgesia, ADLs, adverse side effects, and aberrant behavior. MTUS also requires pain assessment or outcome measures that include current pain, average pain, least pain; intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. This patient has been prescribed Tramadol since at least 06/06/14. Progress reports note that alleviating factors include exercise/PT, medications and rest. Progress report dated 06/06/14 states "c/o headaches associated with Tramadol." Progress report dated 06/30/14 states that medications were not approved, but in the past Tramadol "allowed him to function without pain". In this case, recommendation for further use cannot be supported as the treating physician has not provided any specific functional improvement, changes in ADL's or change in work status to document significant functional improvement with utilizing long term opiate. There are no before and after pain scales provided to denote a decrease in pain with utilizing long-term opioid. Furthermore, there are no discussions regarding aberrant behaviors or adverse side effects as required by MTUS for opiate management. The treating physician has failed to provide the minimum requirements as required by MTUS for opiate management. This request IS NOT medically necessary and recommendation is for slow weaning per MTUS.

Voltaren topical gel 1% 120 gm with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), NSAIDs (non-steroidal anti-inflammatory drugs).

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

Decision rationale: This patient has a date of injury of 04/11/11 and presents with neck, shoulder and low back pain. The back pain radiates into the buttocks. The Request for Authorization is not provided in the medical file. The current request is for Voltaren Topical Gel 1% 120 Gm with 4 Refills. For topical agents, the MTUS Guidelines page 111 states, "Topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety". MTUS further states "Neuropathic pain: Not recommended as there is no evidence to support. FDA approved agent: Voltaren gel 1% (Diclofenac): Indicated for relief of osteoarthritis pain and joints that lend themselves to topical treatment, ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for the treatment of the spine, hip, or shoulder". In this case, the patient presents with neck, low back and shoulder pain. This patient does not meet the indication for this medication as he does not present with osteoarthritis and tendinitis.

Topical NSAID is recommended for acute and chronic pain conditions, particularly arthritis affecting the peripheral joints. The requested Voltaren gel IS NOT medically necessary.

Cymbalta 30mg #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Anti-depressants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Medications for chronic pain Page(s): 16-17, 60.

Decision rationale: This patient has a date of injury of 04/11/11 and presents with neck, shoulder and low back pain. The back pain radiates into the buttocks. The Request for Authorization is not provided in the medical file. The current request is for Cymbalta 30mg #30 with 3 Refills. For Cymbalta, the MTUS Guidelines page 16 and 17 states, "Duloxetine (Cymbalta) is FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. It is also used off-label for neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy."The patient has been prescribed Cymbalta since at least 06/06/14. The medical reports document a decrease in function and increase in pain. The treating physician has stated that the patient has failed medication therapy and is recommending a functional restoration program. The MTUS guidelines page 60 states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Given the lack of discussion regarding medication efficacy, recommendation for further use cannot be made. This request IS NOT medically necessary.