

Case Number:	CM15-0046156		
Date Assigned:	03/18/2015	Date of Injury:	08/13/2003
Decision Date:	05/06/2015	UR Denial Date:	02/14/2015
Priority:	Standard	Application Received:	03/11/2015

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: Arizona, California, Florida
 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 38-year-old female who reported an injury on 08/13/2003. The mechanism of injury was not specifically stated. The current diagnoses include impingement syndrome of the right shoulder, status post decompression with labral repair, cubital tunnel syndrome on the right, status post cubital tunnel release, stenosing tenosynovitis along the first extensor on the right, status post first extensor tendon release, discogenic cervical condition, CMC joint inflammation of the right thumb, status post multiple injections for the right thumb, numbness in the left upper extremity, and elements of depression and weight gain. The injured worker presented on 02/19/2015 with complaints of persistent pain in the upper extremities and neck along with intermittent numbness and tingling. The injured worker had utilized heat and ice application without relief of symptoms. Upon examination, there was tenderness along the cervical paraspinal muscles, pain along the right shoulder rotator cuff, pain along the biceps tendon, right elbow medial and lateral epicondyle tenderness, CMC joint tenderness, first extensor tenderness and tenderness over the dorsum of the wrist. Recommendations included continuation of the current medication regimen. A request for authorization form was then submitted on 02/19/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Tramadol ER 150mg, #30 (DOS 01/19/2015): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the injured worker has continuously utilized the above medication since at least 08/2014. There is no documentation of objective functional improvement. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

Retrospective: Effexor XR 75mg, #60, (DOS 01/19/2015): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 123.

Decision rationale: The California MTUS Guidelines state Effexor is recommended as an option in first line treatment of neuropathic pain. It has FDA approval for treatment of depression and anxiety disorders. It is unclear whether the injured worker currently utilizes Effexor XR for depression or neuropathic pain. Additionally, the injured worker has continuously utilized the above medication since 09/2014. There was no mention of functional improvement despite the ongoing use of this medication. There is also no frequency listed in the request. As such, the request is not medically appropriate at this time.

Retrospective: Norco 10/325mg, #60 (DOS 01/19/2015): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the injured worker has continuously utilized the above medication since at least 08/2014. There is no documentation of objective functional improvement. There is

also no frequency listed in the request. Given the above, the request is not medically appropriate.

Retrospective: Trazadone 50mg, #60 (DOS 01/19/2015): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Trazodone (Desyrel).

Decision rationale: The Official Disability Guidelines recommend trazodone as an option for insomnia only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. In this case, the injured worker has continuously utilized the above medication since at least 09/2014. There is no mention of functional improvement despite the ongoing use of this medication. The injured worker does not maintain a diagnosis of insomnia disorder and the medical necessity for the requested medication has not been established. In addition, there is no frequency listed in the request. Given the above, the request is not medically appropriate.

Retrospective: Lidopro Cream, quantity 1 (DOS 01/19/2015): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: The California MTUS Guidelines state any compounded product that contains at least one drug or drug class that is not recommended as a whole. Lidocaine is not recommended in the form of a cream, lotion, or gel. In this case, it is noted that the injured worker has continuously utilized LidoPro cream since at least 08/2014. There is no evidence of objective functional improvement despite the ongoing use of this medication. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.