

<b>Case Number:</b>	CM15-0087522		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	04/15/2012
<b>Decision Date:</b>	06/19/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/06/2015

### 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: 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 47-year-old female, who sustained an industrial injury on 4/15/12. She reported right shoulder pain, right hand pain, and right wrist pain. The injured worker was diagnosed as having right shoulder sprain status post arthroscopic rotator cuff tear x2, status post biceps tendonitis, right pectoral strain, cervical and trapezial sprain / strain, and sternocleidomastoid pain. Evaluations included electrodiagnostic studies and MRIs. Treatment to date has included medication, 2 right shoulder surgeries, physical therapy, and acupuncture. Physical therapy and acupuncture were noted not to have fully alleviated the pain. Currently, the injured worker complained of pain in the right sternocleidomastoid, pain in the anterior shoulder pain, and mild pain at the base of the thumb with episodic numbness. The treating physician requested authorization for Tramadol ER 150mg #30 and Relafen 750mg #60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol ER 150 MG Qty 30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-9, Chronic Pain Treatment Guidelines Medications for chronic pain; Opioids Page(s): 60-1, 74-96.

**Decision rationale:** Tramadol is a narcotic pain reliever with mu-receptor opioid agonist activity and is used to treat moderate to severe pain. Tramadol ER is an extended release formulation of this medication. Appropriate dosing should not exceed 400 mg/day and it should be used with caution in any patient taking Selective Serotonin Reuptake Inhibitors (SSRI) as together they may cause a potentially fatal condition known as Serotonin Syndrome. There are no studies showing effective use of this medication for chronic pain that lasts greater than 3 months.

However, the MTUS describes use of narcotics for control of chronic pain. Even though this is not considered a first-line therapy, the chronic use of narcotics is a viable alternative when other therapeutic modalities have been tried and failed. Success of this therapy is noted when there is significant improvement in pain or function. The risk with this therapy is the development of addiction, overdose or death. The pain guidelines in the MTUS directly address this issue and have criteria for the safe use of chronic opioids. The patient's medical records showed use of tramadol for over three months. However, in the medical records available for review there was no documentation of a trial of first-line medications, a patient contract, urine drug screens or effectiveness of medication is either controlling pain or improving function. All of these are requirements as per the MTUS for safe use of chronic opioids. The request is not medically necessary.

**Relafen 750 MG Qty 60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73.

**Decision rationale:** Nabumetone (Relafen) is a non-steroidal anti-inflammatory medication (NSAID). NSAIDs as a group are recommended for treatment of osteoarthritis and for short-term use in treating symptomatic pain from joint or muscle injury. In fact, MTUS guidelines notes that studies have shown use of NSAIDs for more than a few weeks can retard or impair bone, muscle, and connective tissue healing and perhaps even cause hypertension. This patient has had stable chronic pain for over 12 weeks and thus can be considered past the point where NSAIDs should be of value in treatment unless used short-term for exacerbation of the patient's chronic injuries. The patient has been on daily use of this medication for over 6 months. Additionally, in the medical records available for review there is no documentation that use of this medication is helping the patient. As the records do not show instructions to the patient for use of this medication only for exacerbations nor any documentation of the effectiveness of this therapy there is no indications for continued use at this time. The request is not medically necessary.

