

Case Number:	CM15-0087724		
Date Assigned:	05/11/2015	Date of Injury:	12/21/2012
Decision Date:	06/11/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/07/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 64-year-old male who sustained a work related injury December 21, 2012. According to a primary treating physician's progress report, dated April 14, 2015, the injured worker presented with complaints of chronic low back pain with pain and numbness radiating down the right leg and foot. There is right shoulder pain and popping, bilateral elbow pain when any pressure is applied, bilateral wrist pain and numbness of both hands (greater pain in both thumbs), and also trigger fingers on both hands 3rd, 4th and 5th fingers. There is diminished sensation all fingers, bilaterally. An MRI dated 11/18/2013, revealed disc protrusion L3-4 (2mm) and L5-S1(3mm) and disc bulge L4-5 (1mm). Diagnoses are; overuse syndrome, bilateral upper extremities; internal derangement, right shoulder; tendinitis, right shoulder; medial epicondylitis and cubital tunnel syndrome, bilateral elbows; carpal tunnel syndrome, bilateral wrists; DeQuervain's tendinitis, bilateral wrists. At issue, is the request for authorization for Methocarbamol (Robaxin) and Tramadol.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg #200 with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

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

Decision rationale: According to MTUS guidelines, Ultram (Tramadol) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. There is no clear recent and objective documentation of pain and functional improvement in this patient with previous use of Tramadol. There is no clear documentation of compliance and UDS for previous use of tramadol. Therefore, the prescription of Tramadol 50mg QTY: 200, with 4 refills is not medically necessary.

Methocarbamol 740mg #90 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: According to MTUS guidelines, non-sedating muscle relaxants are recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic back pain and spasm. Efficacy appears to diminish over time and prolonged use may cause dependence. There is no documentation of recent relief of symptoms and the prolonged use of muscle relaxants is not justified. The prescription of Methocarbamol 740mg #90 with 5 refills is not medically necessary.