

Case Number:	CM14-0149466		
Date Assigned:	09/18/2014	Date of Injury:	08/23/2000
Decision Date:	10/17/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/15/2014

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. The expert reviewer is Board Certified in Geriatrics and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 man with a date of injury of 8/23/00. He was seen by his pain physician on 7/9/14 for his chronic knee pain. His medications included Tramadol for pain, Voltaren gel for pain, and Trazodone for sleep. He was referred to his orthopedic surgeon for follow up of bilateral knee replacements and medications were refilled. He was seen by his orthopedic physician on 8/11/14 for a knee check up. He has metastatic colon cancer and a recent left hip fracture. He was said to be functioning well with good cognition. He is status post bilateral total knee replacements in 2004 and 2007. His exam showed full range of motion of the hips and 'a little pain' in the knee with rotation of the left hip. Both knees were stable with no joint pain or effusion and both had full motion. X-rays were ok and his knee replacements were said to be well functioning. At issue in this review are the request for medications Tramadol, Trazodone and Voltaren gel. Prior length of therapy is not documented in the note.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL 50MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Tramadol is a centrally acting analgesic reported to be effective in managing neuropathic pain. This worker has no history of neuropathic pain. The MD visits fail to document any improvement in pain, functional status or side effects to justify ongoing use. His knees were in good alignment status post replacement with minimal pain on exam. The medical necessity of Tramadol for knee pain is not substantiated in the records. Therefore, this request is not medically necessary.

VOLTAREN 1% GEL: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 111-112.

Decision rationale: Topical analgesics are largely experimental with few randomized trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder and there is no evidence to support its use in neuropathic pain. This worker has well aligned joint replacements and minimal pain on physical exam. Given the lack of evidence, the records do not provide clinical evidence to support medical necessity. Therefore, this request is not medically necessary.

TRAZODONE 50 MG #60: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 13-14.

Decision rationale: Trazodone is an anti-depressant and is a serotonin antagonist and reuptake inhibitor. Anti-depressants can be used as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. In this case, the notes do not document any difficulty with sleeping and there is no documentation of a discussion of side effects or efficacy. The records do not support medical necessity for Trazodone. Therefore, this request is not medically necessary.