

Case Number:	CM14-0218901		
Date Assigned:	01/08/2015	Date of Injury:	08/16/2012
Decision Date:	03/12/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/30/2014

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. 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, Arizona

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:

This is a 40 year old female who sustained a work related injury on 8/16/2012. The mechanism of injury was repetitive work. Per the Primary Treating Physician's Progress Report dated 11/06/2014 the injured worker reported lower back pain, rated as a 7 out of 10 on a 0-10 pain scale with radiation to left lower extremity. She also reported right shoulder pain, described as 7 out of 10, becoming an 8 with forceful motion at or above shoulder level. She also describes bilateral wrist/hand pain and numbness, 6 out of 10, becoming an 8 with forceful gripping or grasping. Pain decreases to a 6/10 from an 8/10 with medications. Objective physical examination reveals decreased range of motion in the lumbar spine. There is a positive straight leg raise test on the left at 60 degrees, with radiation pain to the posterior thigh. There is decreased range of motion in the right shoulder in all planes. Forward flexion and abduction is 140/180, internal and external rotation is 60/90. Impingement test is positive. There is decreased range of motion in the bilateral wrists, 40/60 with both flexion and extension. Phalen's test is positive. Diagnoses include chronic cervical strain, chronic lumbar strain, rule out disc herniation, left shoulder rotator cuff syndrome, left lower extremity radicular pain and bilateral wrist tendinitis/rule out carpal tunnel syndrome. The plan of care includes follow-up care with specialists including a psychiatrist and sleep consultation. Work Status is modified. On 12/03/2014, Utilization Review non-certified prescriptions for a urine toxicology screen and Kera-Tek gel and modified a prescription for Ultram 50mg #120 based on lack of medical necessity. The CA MTUS Chronic Pain Medical Treatment Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine toxicology screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug screen- Opioids,.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

Decision rationale: The California Medical Treatment Utilization Schedule indicates that the use of urine drug screening is for patients with documented issues of abuse, addiction, or poor pain control. There was a lack of documentation indicating the injured worker had documented issues of abuse, addiction or poor pain control. Given the above, the request for urine toxicology screen is not medically necessary.

Kera-Tek gel: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines salicylate topical Page(s): 105.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend salicylate topicals. However, there was a lack of documented rationale for the requested medication. The request, as submitted, failed to indicate the quantity and body part to be treated with the Kera-Tek gel. Given the above, the request for Kera-Tek gel is not medically necessary.

Ultram (Tramadol) 50mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain; ongoing management Page(s): 60; 78.

Decision rationale: The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the patient is being monitored for aberrant drug behavior and side effects. The injured worker indicated she had improvement in her pain level from 8/10 to 6/10 with the use of medications. the injured worker was being monitored for aberrant drug behavior and side effects. However, there was a lack of documentation of objective functional improvement and an objective decrease in pain. Additionally, the request, as submitted, failed to

indicate the frequency for the requested medication. Given the above, the request for Ultram (tramadol) 50 mg #120 is not medically necessary.