

Case Number:	CM15-0013217		
Date Assigned:	01/30/2015	Date of Injury:	08/11/2012
Decision Date:	03/18/2015	UR Denial Date:	01/02/2015
Priority:	Standard	Application Received:	01/22/2015

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: Hawaii, 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 (IW) is a 57 year old female who sustained an industrial injury on 08/11/2012. She has reported pain in the wrist and hand with difficulty gripping, grasping, and torking. Diagnoses include carpal tunnel syndrome on the left, wrist joint inflammation with ulnar impaction, inflammation of the thumb on the left, chronic pain related depression, sleep and stress issues. Treatments to date include diagnostic tests of MRI and nerve conduction studies, activity restrictions, immobilization, use of heat and cold therapeutically, TENS (Transcutaneous Electrical Nerve Stimulation) unit use, medications and injections. In a progress note dated 12/17/2014, the treating provider notes the IW had issues with sleep, stress, and depression. There is tenderness along the ulnar condyle of the left wrist, and tenderness along the left rotator cuff with finding of impingement and tenderness noted along the first extensor. The IW has difficulty sleeping and is tearful with pain. On 01/02/2015 Utilization Review non-certified a request for Tramadol ER 150 mg # 30 noting the medication is indicated for moderate to severe pain with ongoing review and documentation of pain relief and duration of pain relief. The monitoring of these outcomes over time should affect therapeutic decisions. The MTUS Chronic Pain, Opioids was cited. On 01/02/2015 Utilization Review non-certified a request for Trazodone 50 mg # 60 noting that a clear response from any prior Trazadone use is not identified, and evidence of a co-morbid depression is not identified. Based on these points, the medical necessity for Trazodone is not provided. The non-MTUS, Official Disability Guidelines (ODG) Insomnia Treatment was cited. On 01/02/2015 Utilization Review non-certified a request for Nalfon 400 mg # 60, noting the analgesic response to prior Tramadol and

Nalfon use was not objectively documented. The MTUS, ACOEM Guidelines, (or ODG) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol ER 150 mg # 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol, Ultram Page(s): 74-96, 113, 123. Decision based on Non-MTUS Citation Pain (Chronic) - Medications for acute pain (analgesics), Tramadol (Ultram)

Decision rationale: Tramadol is classified as central acting synthetic opioids. MTUS states regarding tramadol that "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." ODG further states, "Tramadol is not recommended as a first-line oral analgesic because of its inferior efficacy to a combination of Hydrocodone/ acetaminophen." The treating physician did not provide sufficient documentation that the patient has failed a trial of non-opioid analgesics at the time of prescription or in subsequent medical notes. Additionally, no documentation was provided which discussed the setting of goals for the use of tramadol prior to the initiation of this medication. As such, the request for Tramadol ER 150 mg # 30 is not medically necessary as written.

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) Insomnia Treatment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mental Illness and Stress, Trazodone

Decision rationale: Regarding Trazodone, the above cited guidelines say: "Recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. See also Insomnia treatment, where it says there is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression. The current recommendation is to utilize a combined pharmacologic and psychological and behavior treatment when primary insomnia is diagnosed. Also worth noting, there has been no dose-finding study performed to assess the dose of trazodone for insomnia in non-depressed patients. Other pharmacologic therapies should be recommended for primary insomnia before considering trazodone, especially if the insomnia is not accompanied by comorbid depression or recurrent treatment failure. There is no clear-cut evidence to recommend

trazodone first line to treat primary insomnia. "The medical records do indicate a diagnosis of "element of depression", but no other workup or behavior health evaluation was detailed in the provided medical notes. The notes do not detail insomnia symptoms or evaluation for such symptoms. The coexisting treatment of depression and insomnia is not established at this time. As such, the request for Trazodone 50 mg # 60 is not medically necessary.

Naflon 400 mg # 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72. Decision based on Non-MTUS Citation Pain, Fenoprofen (Nalfon)

Decision rationale: MTUS recommends the use of NSAIDS for the acute exacerbation of back pain at the lowest effective dose for the shortest amount of time due to the increased cardiovascular risk, renal, hepatic and GI side effects associated with long term use. Fenoprofen (Nalfon, generic available): 200, 600 mg. Dosing: osteoarthritis; (off-label use for ankylosing spondylitis); 300 '600mg PO 3 to 4 times per day (Max daily dose is 3200mg). Improvement may take as long as 2 to 3 weeks. Mild to moderate pain (off-label use for bone pain): 200mg PO every 4 to 6 hours as needed. The medical records do not indicate osteoarthritis, but do detail some level of pain. The medical notes, do not, however, detail the pain level or other measurement to effectively compare improvement of function while on this medication. The documented improvement while on pain medication is necessary for continued treatment. Given, the lack of this documentation, the request for nalfon can not be granted at this time. As such, the request for Naflon 400 mg # 60 is not medically necessary.