

Case Number:	CM15-0112247		
Date Assigned:	06/19/2015	Date of Injury:	12/19/2009
Decision Date:	09/22/2015	UR Denial Date:	06/01/2015
Priority:	Standard	Application Received:	06/10/2015

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: Pennsylvania

Certification(s)/Specialty: Internal Medicine, Hospice & Palliative 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 37 year old male patient who sustained an industrial injury on 12/19/2009. On 03/13/2012 the patient underwent a magnetic resonance imaging study of thoracic spine that showed a broad based central disc herniation at T11-T12 with mild central spinal canal stenosis. The right elbow 03/13/2012 showed a loss in articular cartilage overlying the capitellum with subchondral edema, suspicious for osteochondral injury or erosion. There is a slight flattening of the articular surface of the capitellum and subchondral edema at the dorsal margin of the radial head; there is moderate joint effusion. A follow up visit on 07/13/2012 found the patient with subjective complaint of being frustrated with the dealings of the case. There is mention of recommendation to undergo surgical intervention, right arthroscopy of elbow and continued denials. He is having great trouble sleeping at night. He is stressed, depressed, and cannot sleep. He complains of a lot of pain along the A1 pulley of the little finger as well as dorsal metacarpal discomfort. The patient has motion loss and stiffness with the elbow, mid back pain and low back pain with spasm. Objective assessment noted the patient with hypertonicity at T9 to L5 bilaterally. There is exquisite tenderness along the L1, T11, and T12. He has tightness at paraspinals, bilateral latissimus dorsi, and quadratus lumborum. The left knee is with tenderness along the medial joint line. McMurray's test is positive on let medially. There is also tenderness at anterior talofibular ligament and lateral joint line of the ankle. The following diagnoses are applied: discogenic lumbar condition with radicular component; internal derangement of the left knee; sinus tarsi syndrome on the left; epicondylitis medially on the right; stenosing tenosynovitis along the A1 pulley of the long finger on right and

MP joint inflammation of the long finger on the right; impingement syndrome with rotator cuff tear on left; shoulder girdle sprain and some nonspecific neck involvement; an element of ulnar nerve entrapment of the left elbow. The plan of care noted recommending course of therapy as well as surgical intervention right elbow. The patient received prescription for: Tizanidine; Topamax; Norco; Tramadol ER; Prilosec; and Dendracin lotion. A recent follow up dated 05/12/2015 reported subjective complaint of left ankle, mid/low back, left knee, right elbow and left shoulder pains. He reports taking medications to be functional. The patient is requesting an injection to the right elbow. The following diagnoses are given: wedge fracture at T11-T12; disc disease at L3-4, L4-5 with radicular component; nerve study with negative findings and MRI of lumbar spine showed protrusions with effacement and facet changes through L1-S1; patellar chondromalacia left; anterior talofibular ligament injury along the left ankle, MRI with partial tear of peroneal longus and brevis tendons; stenosing tenosynovitis along the A1 pulley of the thumb on the right; impingement syndrome left, status post repair with significant improvement; depression and sleep along with radial collateral injury ligament of the long finger on the right, and medial epicondylitis, right, status post injection. The patient was administered a Cortisone injection right elbow.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) cortisone injection to the ulnar nerve: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 25.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 1-52.

Decision rationale: The ACOEM Guidelines support the use of steroid injections for some cases of lateral or medial epicondylitis for short-term relief only if at least three to four weeks of conservative primary treatment failed to improve the symptoms. If an adjuvant medication is also injected with a steroid, bupivacaine has been found to be superior and is preferred. The submitted and reviewed documentation indicated the worker was experiencing problems sleeping and pain in the mid- and lower back with spasms and stiffness, left knee, right ankle, left shoulder, and right elbow. These records concluded the worker was suffering from medial epicondylitis, among other conditions. However, the request did not specify the side to be injected. For these reasons, the current request for a cortisone injection to the unspecified ulnar nerve is not medically necessary.

Tramadol ER (extended release) 150mg, #30 dispensed on 5/12/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list: Tramadol (Ultram; Ultram ER; generic available in immediate release tablet); Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Weaning of Medications Page(s): 74-95, page 124.

Decision rationale: Tramadol-ER is a long-acting medication in the opioid class. The MTUS Guidelines stress the lowest possible dose of opioid medications should be prescribed to improve pain and function, and monitoring of outcomes over time should affect treatment decisions. Documentation of pain assessments should include the current pain intensity, the lowest intensity of pain since the last assessment, the average pain intensity, pain intensity after taking the opioid medication, the amount of time it takes to achieve pain relief after taking the opioid medication, the length of time the pain relief lasts, use and of drug screening with issues of abuse or addiction. Acceptable results include improved function, decreased pain, and/or improved quality of life. The MTUS Guidelines recommend opioids be continued when the worker has returned to work and if the worker has improved function and pain control. When these criteria are not met, an individualized taper is recommended. The submitted and reviewed records indicated the worker was experiencing problems sleeping and pain in the mid- and lower back with spasms and stiffness, left knee, right ankle, left shoulder, and right elbow. The recorded pain assessments contained few of the elements suggested by the Guidelines. There was no discussion detailing how this medication improved the worker's function, describing how often the medication was needed and used by the worker, exploring the potential negative side effects, or providing an individualized risk assessment. In the absence of such evidence, the current request for 30 tablets of tramadol-ER 150mg for the date of service 05/12/2015 is not medically necessary. While the Guidelines support the use of an individualized taper to avoid withdrawal effects, the risks of continued use significantly outweigh the benefits in this setting based on the submitted documentation, and a wean should be able to be completed with the medication available to the worker.

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indicated the worker was experiencing problems sleeping and pain in the mid- and lower back with spasms and stiffness, left knee, right ankle, left shoulder, and right elbow. The recorded pain assessments contained few of the elements suggested by the Guidelines. There was no discussion detailing how this medication improved the worker's function, describing how often the medication was needed and used by the worker, exploring the potential negative side effects, or providing an individualized risk assessment. In the absence of such evidence, the current request for 30 tablets of tramadol-ER 150mg is not medically necessary. While the Guidelines support the use of an individualized taper to avoid withdrawal effects, the risks of continued use significantly outweigh the benefits in this setting based on the submitted documentation, and a wean should be able to be completed with the medication available to the worker.

Naproxen 550mg, #60 dispensed on 5/12/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen; NSAIDs, specific drug list & adverse effects.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

Decision rationale: Naproxen sodium is in the non-steroidal anti-inflammatory drug (NSAID) class of medications. The MTUS Guidelines support the use of NSAIDs in managing osteoarthritis-related moderate to severe pain. The Guidelines stress the importance of using the lowest dose necessary for the shortest amount of time. They further emphasize that clinicians should weigh the benefits of these medications against the potential negative effects, especially in the setting of gastrointestinal or cardiovascular risk factors. The submitted and reviewed records indicated the worker was experiencing problems sleeping and pain in the mid- and lower back with spasms and stiffness, left knee, right ankle, left shoulder, and right elbow. The documented pain assessments did not include many of the elements recommended by the Guidelines. There was no documentation describing how long the benefit lasted, the worker's gastrointestinal and heart risks, or results of laboratory monitoring tests. The Guidelines stress the importance of on-going monitoring of both the benefits and risks of this medication, and long-term use carries increasing risks. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for sixty tablets of naproxen 550mg for the date of service 05/12/2015 is not medically necessary.

Naproxen 550mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen; NSAIDs, specific drug list & adverse effects.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

Decision rationale: Naproxen sodium is in the non-steroidal anti-inflammatory drug (NSAID) class of medications. The MTUS Guidelines support the use of NSAIDs in managing osteoarthritis-related moderate to severe pain. The Guidelines stress the importance of using the

lowest dose necessary for the shortest amount of time. They further emphasize that clinicians should weigh the benefits of these medications against the potential negative effects, especially in the setting of gastrointestinal or cardiovascular risk factors. The submitted and reviewed records indicated the worker was experiencing problems sleeping and pain in the mid- and lower back with spasms and stiffness, left knee, right ankle, left shoulder, and right elbow. The documented pain assessments did not include many of the elements recommended by the Guidelines. There was no documentation describing how long the benefit lasted, the worker's gastrointestinal and heart risks, or results of laboratory monitoring tests. The Guidelines stress the importance of on-going monitoring of both the benefits and risks of this medication, and long-term use carries increasing risks. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for sixty tablets of naproxen 550mg is not medically necessary.