

Case Number:	CM15-0116238		
Date Assigned:	06/24/2015	Date of Injury:	03/22/2006
Decision Date:	07/27/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	06/16/2015

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 York

Certification(s)/Specialty: Neurological Surgery

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 58 year old female, who sustained an industrial injury on 03/22/2006. The injured worker reported a left shoulder and upper extremity injury. The injured worker low back pain with a diagnosis of lumbosacral strain. On provider visit dated 05/19/2015 the injured worker has reported low back pain. On examination the shoulder was noted to have some residual left shoulder pain status post-surgery in 2006. Her back was noted as stiff and a decreased range of motion was noted. Straight leg raise was positive bilaterally. The diagnoses have included status post L4-L5 and L5-S1 decompression with fusion of L5-S1, left shoulder status post arthroscopic subacromial decompression and partial claviclectomy and persistent depression, chronic. Treatment to date has included medication: Norco, Tramadol, Flexeril, Prilosec and Naprosyn, TENS unit, laboratory studies and epidural injections. The provider requested spinal cord stimulator trial, urine drug screen, and refill the following: Cyclobenzaprine, compound medicated cream topical cream-Gabapentin, Ketoprofen and Tramadol and oral medication Tramadol.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal cord stimulator trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 107.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations, Indications for stimulator implantations Page(s): 101, 107.

Decision rationale: The California MTUS guidelines recommend a psychological evaluation prior to the spinal cord stimulator trial. The guidelines note that there is evidence of benefits in improved depression care that included decreased pain and improved functional status. Documentation does not show the psychological evaluation. The requested treatment: Spinal cord stimulator trial is NOT Medically necessary and appropriate.

Urine drug screen: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 94-95.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing, opioids ongoing management Page(s): 43, 78.

Decision rationale: The California MTUS guidelines do recommend drug screening when there are issues of poor pain control. Documentation does support ongoing pain despite treatment. They recommend screening if there are issues of abuse and addiction. They recommend screening if there is concern about the presence of illegal drugs. The requested treatment: Urine drug screen is Medically necessary and appropriate.

Cyclobenzaprine 7.5 mg tablets #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41, 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants-antispasmodics-cyclobenzaprine Page(s): 64.

Decision rationale: The California MTUS guidelines recommend cyclobenzaprine for a short course of treatment. They do not recommend chronic use. They recommend a dosing of 5 mg. three times a day. The requested treatment: Cyclobenzaprine 7.5 mg tablets #60 is NOT Medically necessary and appropriate.

Compound Med-Topical cream-Gabapentin, Ketoprofen, Tramadol #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

Decision rationale: The California MTUS guidelines do not recommend Gabapentin used as a topical analgesic. The guidelines recommend the provider have knowledge of the specific analgesic effect of each agent in the compound. Documentation is not provided which illustrates this capability. The requested treatment: Compound Med-Topical cream-Gabapentin, Ketoprofen, Tramadol #1 is NOT Medically necessary and appropriate.

Tramadol 50 mg tablets #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93-94, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for osteoarthritis, Tramadol Page(s): 83-4, 113, 93-4.

Decision rationale: Tramadol is not recommended as a first line oral analgesic. The California MTUS guidelines do not recommend its long term use. The guidelines note adverse events often caused study participants to discontinue the medication. The requested treatment: Tramadol 50 mg tablets #60 Requested Treatment is NOT Medically necessary and appropriate.