

Case Number:	CM15-0117605		
Date Assigned:	06/25/2015	Date of Injury:	04/14/2001
Decision Date:	07/29/2015	UR Denial Date:	06/17/2015
Priority:	Standard	Application Received:	06/18/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 51 year old male, who sustained an industrial injury on April 14, 2001. Treatment to date has included physical therapy, medications, and home exercise. Currently, the injured worker complains of pain in his shoulder, back, hip and knees. He has more numbness in the back and bilateral legs. He reports that his pain is made worse with lying down and with overhead activities as well as with pushing, pulling and lifting above shoulder level. He reports that the pain is relieved with non-weight bearing movement, rest and medications. His pain limits him from some exercise. On physical examination the injured worker has normal muscle tone in the bilateral upper extremities and the bilateral lower extremities. He has normal muscle strength in the bilateral lower extremities. He reports tenderness to palpation over the right lumbar paraspinal muscles and over his buttocks. His sensation is decreased in the dermatome of right L3-L5 and a straight leg raise test is negative. The diagnoses associated with the request include pain in pelvis, pain in thigh, pain in shoulder and degeneration of the lumbar disc. The treatment plan includes Voltaren 1% gel and Tramadol/apap.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol/APAP 37.5/325mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going management Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (1) Opioids, criteria for use, (2) Opioids, dosing Page(s): 76-80, 86.

Decision rationale: The claimant has a remote history of a work injury occurring in April 2001 and continues to be treated for back, shoulder, hip, and knee pain. Medications are referenced as providing a 30% decrease in pain and allowing for improved sitting and walking tolerances. When seen, back pain was preventing him from exercising. There was lumbar paraspinal and buttock tenderness with decreased right lower extremity sensation. Medications being prescribed included nabumetone and Pantoprazole. Voltaren gel was prescribed. Tramadol was refilled. When prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Tramadol/acetaminophen is a short acting combination opioid often used for intermittent or breakthrough pain. In this case, it is being prescribed as part of the claimant's ongoing management. There are no identified issues of abuse or addiction and medications are providing pain control and improved activity tolerances The total MED is less than 120 mg per day consistent with guideline recommendations. Continued prescribing was medically necessary.

Voltaren 1% Gel, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 112.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6, p 131-132.

Decision rationale: The claimant has a remote history of a work injury occurring in April 2001 and continues to be treated for back, shoulder, hip, and knee pain. Medications are referenced as providing a 30% decrease in pain and allowing for improved sitting and walking tolerances. When seen, back pain was preventing him from exercising. There was lumbar paraspinal and buttock tenderness with decreased right lower extremity sensation. Medications being prescribed included nabumetone and Pantoprazole. Voltaren gel was prescribed. Tramadol was refilled. Topical non-steroidal anti-inflammatory medication can be recommended for patients with chronic pain where the target tissue is located superficially in patients who either do not tolerate, or have relative contraindications, for oral non-steroidal anti-inflammatory medications. In this case, oral nabumetone is also being prescribed. Prescribing two non-steroidal anti-inflammatory medications would be duplicative and is not considered medically necessary.