

Case Number:	CM15-0124484		
Date Assigned:	07/09/2015	Date of Injury:	07/18/2005
Decision Date:	08/19/2015	UR Denial Date:	05/29/2015
Priority:	Standard	Application Received:	06/29/2015

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: 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 45-year-old female who sustained an industrial injury on 07/18/2005. Diagnoses include right sacroiliac joint dysfunction; cervical facet arthropathy; cervical myofascial strain; bilateral carpal tunnel syndrome; lumbar myofascial strain; thoracic myofascial strain; cervical and lumbar radiculitis; lumbago; and cervicalgia. Treatment to date has included medications, sacroiliac joint injection, physical therapy and acupuncture. According to the progress notes dated 4/27/15, the IW reported neck pain, back pain, right shoulder and right elbow pain. She rated her neck pain 7-9/10 and mid back and low back pain 10/10. She complained of radiating numbness into her upper extremities into her hands when sleeping and radiation of stabbing pain in the right lower extremity. She had sleeping problems due to pain, awakening every one to four hours. Electrodiagnostic testing of the bilateral upper extremities on 4/16/15 found evidence of bilateral carpal tunnel syndrome. On examination, most of the spinal exam was within normal limits except decreased range of motion of the cervical spine with hypertonicity, tenderness and twitch responses in the cervical paraspinal muscles and the trapezius. Facet loading was positive in the bilateral cervical spine. FABER testing was positive on the right; Gaenslen's was positive on the right; Tinel's and Phalen's were positive bilaterally. A request was made for retrospective review for Ultram 37.5mg, #90 with one refill; Ketoprofen cream 20%; Anaprox 550mg, #60 one refill; and Lunesta 2mg, #30 one.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro anaprox 550mg #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-80, 93, 94, 124.

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

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. The medical record contains no documentation of functional improvement. Retro anaprox 550mg #60 with 1 refill is not medically necessary.

Retro ketoprofen cream 20%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 11-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 ? 9792.26 Page(s): 111.

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Retro ketoprofen cream 20% is not medically necessary.

Retro lunesta 2mg #30 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Insomnia treatment.

Decision rationale: The Official Disability Guidelines do not recommend the long-term use of any class of sleep aid. The patient has been taking Lunesta longer than the maximum recommended time of 4 weeks. The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. At present, based on the records provided, and the evidence-based guideline review, the request is non-certified. Retro lunesta 2mg #30 with 1 refill is not medically necessary.

Retro Ultram 37.5mg #90 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-80, 93, 94, 124.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Ultram is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Despite the long-term use of Ultram, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. Retro Ultram 37.5mg #90 with 1 refill is not medically necessary.