

Case Number:	CM15-0149904		
Date Assigned:	08/05/2015	Date of Injury:	12/27/2013
Decision Date:	10/13/2015	UR Denial Date:	06/26/2015
Priority:	Standard	Application Received:	07/24/2015

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: Connecticut, California, Virginia
 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 is a 25 year old female, who sustained an industrial injury on 12-27-2013. Diagnoses include cervical sprain-strain with bilateral upper extremity radiculopathy, bilateral shoulder tendinitis, bilateral wrist carpal tunnel syndrome. She has a history of gastritis with NSAID therapy. Treatment to date has included diagnostics, chiropractic, medications, modified work, physical therapy, bracing, injections and acupuncture. Per the Primary Treating Physician's Progress Report dated 6-08-2015, the injured worker reported left shoulder pain still rated as 7 out of 10 especially with overhead use. Right shoulder pain is described as very minimal and improved. Neck pain is rated as 5 out of 10 with numbness and tingling into the bilateral hands right greater than left. Objective findings were not documented at this visit. Functional status is described as no change. Work status was modified. Per the medical records dated 12-23-2014 to 6-08-2015, there is not documentation of an increase in activities of daily living or functional improvement. Pain has decreased in the right shoulder as of 6-08-2015 but remains the same in the left shoulder and neck. She has been prescribed Tramadol since at least 1-27-2015 at which time Cyclo-Tramadol cream was also prescribed. On 2-27-2015 Tramadol and Tylenol were discontinued due to fatty liver. The plan of care included medication management and authorization was requested for Tramadol 50mg #60 and Flurbiprofen-Capsaicin cream. On 6-26-2015, Utilization Review non-certified the request for Tramadol 50mg #60 and Flurbiprofen-Capsaicin cream citing lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, criteria for use, Opioids for chronic pain, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, steps to avoid misuse/addiction.

Decision rationale: Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain in this patient since the initial date of injury, consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate. Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case, the patient clearly warrants close monitoring and treatment, to include close follow up regarding improvement in pain/function; consideration of additional expertise in pain management should be considered if there is no evidence of improvement in the long term. More detailed consideration of long-term treatment goals for pain (specifically aimed at decreased need for opioids), and further elaboration on dosing expectations in this case would be valuable. Consideration of other pain treatment modalities and adjuvants is also recommended. It is recommended that appropriate weaning be facilitated. Given the lack of clear evidence to support functional improvement on the medication and the chronic risk of continued treatment, the request for Tramadol is not medically necessary.

Flurbi/Cap Cream Prn: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The MTUS states there is little to no research to support the use of many compounded agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. In this case, there is no evidence of functional improvement provided to indicate that chronic use of the requested cream is of clinical value, and therefore the request is not medically necessary at this time.