

<b>Case Number:</b>	CM13-0028516		
<b>Date Assigned:</b>	11/27/2013	<b>Date of Injury:</b>	12/31/1987
<b>Decision Date:</b>	02/24/2014	<b>UR Denial Date:</b>	09/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management has a subspecialty in Disability Evaluation and is licensed to practice in California, Maryland, Florida and District of Columbia. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient reported a 12/31/1987 date of injury. A specific mechanism of injury has not been described. The 8/27/13 progress report indicates persistent and increased posterior right hip pain. Physical exam demonstrates painful and antalgic gait, lumbar tenderness. Treatment to date has included chiropractic care, lumbar ESI, orthotics, walker, medication, and activity modification. The request is for 1. Vicodin 7.5mg/500mg po q8h, prn 30 days #90 (8/27/13-9/25/13), 2. Voltaren Gel 1 %, 2-4 Gram(s), TOP, tid, 30days, for a total of 100 x3 (8/27/13-9/25/13).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Vicodin 7.5mg/500mg po q8h, prn 30 days #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75-76..

**Decision rationale:** Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are

prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, an opioid utilization time line was not established in this case. There is sparse information in the most recent medical report as to the domains of ongoing opioid management, including monitoring for diversion, abuse, side effects, or tolerance development; dosage -adjustments, attempts to wean and taper, endpoints of treatment; and continued efficacy and compliance.. (Hydromorphone) is a Short-acting opioids: also known as "normal-release" or "immediate-release" opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. These agents are often combined with other analgesics such as acetaminophen and aspirin. These adjunct agents may limit the upper range of dosing of short acting agents due to their adverse effects. The duration of action is generally 3-4 hours. CA-MTUS further stated that "Failure to respond to a time-limited course of opioids leads to the suggestion of reassessment and consideration of alternative therapy. Opioids are recommended as the standard of care for treatment of moderate or severe nociceptive pain (defined as pain that is presumed to be maintained by continual injury, with the most common example being pain secondary to cancer)."

**Voltaren Gel 1%, 2-4 gram(s): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 81..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112..

**Decision rationale:** CA-MTUS (effective July 18, 2009) section on Topical Analgesics, page 111 to 112 of 127 states that there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. FDA-approved agents: Voltaren® Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). Therefore the prescription of Voltaren Gel 1%, 2-4 gram(s), TOP, tid, 30 days for a total of 100 x 3 was not medically necessary.