

<b>Case Number:</b>	CM13-0028951		
<b>Date Assigned:</b>	11/01/2013	<b>Date of Injury:</b>	06/12/2002
<b>Decision Date:</b>	02/19/2014	<b>UR Denial Date:</b>	09/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2013

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois, Indiana, and Texas. 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:

The patient is a 44-year-old female who reported an injury on 02/27/2002 due to cumulative trauma while performing normal job duties. The patient developed elbow and wrist pain. This was conservatively treated with physical therapy, work station ergonomic modifications, splinting, and medications. The patient's most recent clinical exam findings included ongoing right elbow pain. Objective findings included tenderness to the right elbow over the medial and lateral epicondyle with decreased grip strength in the right hand. The patient's diagnoses included carpal tunnel syndrome, tenosynovitis of the hand/wrist, skin sensation disturbance, lumbar sprain/strain, lumbar discopathy/disc herniation, status post right hip replacement, depression and anxiety. The patient's treatment plan included shockwave therapy, continued medication usage, and a home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Amitriptyline 4%-Tramadol 20%, 240gm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Topical Analgesics, and Effectiveness of topical admin.

**Decision rationale:** The requested amitriptyline 4%/tramadol 20% 240 g, for dates of service 11/18/2010, 06/03/2011, and 09/30/2011 are not medically necessary or appropriate. The clinical documentation submitted for review did not provide any evidence of medical necessity for pain management for the requested dates. There were no clinical evaluations to determine the need for medication management. California Medical Treatment Utilization Schedule does not recommend the use of topical analgesics as a first line treatment due to lack of scientific evidence to support the efficacy of this type of treatment. Additionally, peer reviewed literature does not recommend the topical use of antidepressants or opioids due to lack of scientific evidence to support the efficacy of these topical medications. There is no way to determine the need for these medications for the requested date and the requested topical analgesic is not supported by guideline recommendations or peer reviewed literature. The requested medication is not indicated. As such, the amitriptyline 4%/tramadol 20%, 240 g, dates of service 11/18/2010, 06/03/2011, and 09/30/2011 is not medically necessary or appropriate.

**Dicolenac Sodium 30% 240gm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Topical Analgesics Page(s): 111..

**Decision rationale:** The requested diclofenac sodium 30% 240 g for dates of service 11/18/2010, 06/03/2011, and 09/30/2011 are not medically necessary or appropriate. There was no clinical documentation submitted for the requested dates to determine the medical necessity of medication management. California Medical Treatment Utilization Schedule recommends the use of topical anti-inflammatory when the patient is intolerant or oral medications are contraindicated for the patient. The clinical documentation submitted for review does not provide any evidence that the patient has history of intolerance to anti-inflammatory medications. Additionally, as there is no documentation to support the need for this type of medication for the requested dates, it would not be indicated. As such, the requested diclofenac sodium 30%, 240 g, dates of service 11/18/2010, 06/03/2011, and 09/030/2011 it not medically necessary or appropriate.