

<b>Case Number:</b>	CM13-0031438		
<b>Date Assigned:</b>	05/21/2014	<b>Date of Injury:</b>	11/20/2011
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	09/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/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 is a 56-year-old female with date of injury of November 20, 2001. Per treating physician's report September 13, 2013, active problems include carpal tunnel syndrome, de Quervain's syndrome and tenosynovitis. Current medications include Voltaren gel, Ambien, Excedrin, KGCL topical cream, Levothyroxine, Lisinopril, Lovastatin, Robaxin, and Tramadol. September 11, 2013 report is a letter indicating that the patient has bilateral forearm pain due to accumulative trauma, work-related injury, wrist-hand pain with prior bilateral distal ulnar resection shortening, carpal tunnel release, and de Quervain's release in 2003 and 2004. The combination of Voltaren 1% gel and KGCL cream has significantly improved the patient's mental clarity, decreasing her oral medication, improving her pain. The patient was to continue current medications as well as heat, ice. Next report available is May 7, 2013 which she complains of continued bilateral forearm, wrist-hand pain, intermittent hand cramping with current medication include Voltaren gel, Ambien, Excedrin, KGCL, etc., and Robaxin, etc. Pain ranges from 3/10 to 8/10 left usually worse than right. The patient is stable and wants to continue with current medications for additional 6 months including 1% Voltaren gel, KGCL cream, Robaxin, and rare use of Vicodin. There is also a report from January 27, 2014 list of same medications but having worsening symptoms due to denial of KGCL cream or 1% Voltaren gel. The patient's forearm pain ranges in severity 5/10 to 9/10, continues to utilize strengthening exercises, paraffin wax, heat, ice on a regular basis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**VOLTAREN GEL 1% 200GM (X3MONTHS):** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** This patient presents with chronic bilateral upper extremity pains with prior history of ulnar shortening, de Quervain's release bilaterally and carpal tunnel releases. Without the Voltaren gel, pain increased to 5/10 to 9/10 from 3/10 to 8/10 in range. MTUS Guidelines support topical non-steroidal anti-inflammatory drugs (NSAIDs) for peripheral joint arthritis/tendinitis problems. This patient suffers from de Quervain's carpal tunnel syndrome, tendinitis of the wrist. MTUS Guidelines support topical NSAIDs for this type of conditions and the treating physician adequately documents this topical cream has been helpful. Therefore the request for Voltaren Gel 1% 200gm (x3 months) is medically necessary.

**VICODIN 5/500MG #28 (X3 REFILLS):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Long-Term Assessment Page(s): 88-89.

**Decision rationale:** This patient presents with bilateral upper extremity pains due to repetitive trauma disorder. The request is for Vicodin #28. Review of reports from 2013 and up to January 2014 does not show documentation that this patient is actually using Vicodin. Another reports referenced that the patient is using Vicodin on as needed basis but does not explain how the patient is responding to the use of Vicodin. For chronic opiate use, even on an intermittent basis, MTUS Guidelines require documentation for pain, function, analgesia, activities of daily living, adverse effects, and aberrant drug-seeking behavior. In this case, there is no discussion regarding this medication's efficacy and no opiate usage monitoring is provided. Therefore the request for Vicodin 5/500mg #28 (X3 Refills) is not medically necessary.

**AMBIEN 10MG #28 (X3 REFILLS):** 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), Pain Chapter, Zolpidem.

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

**Decision rationale:** This patient presents with bilateral upper extremity pains and the request is for Ambien for the patient's insomnia. ODG Guidelines only allow short-term use of Ambien for insomnia. Long-term use is not recommended. In this case, review of multiple reports show that this patient has been on Ambien for quite some time and appears to be used for long-term basis. Therefore the request for Ambien 10 mg #28 (x3 refills) is not medically necessary.

**KGCL CREAM (KETAMINE HYDROCHLORIDE) 10/6/0.2/5% 60 MGS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

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

**Decision rationale:** This patient presents with chronic bilateral upper extremity pains due to repetitive trauma disorder. The patient has had multiple surgeries of the upper extremities. The request was for KGCL topical cream which contains Ketamine, Gabapentin, Cyclobenzaprine, and Lidocaine. MTUS Guidelines states that if one of the components of topical combination cream is not recommended, then the entire compound is not recommended. In this case, Ketamine is only recommended for neuropathic pain that is refractory to other treatments, Cyclobenzaprine topical cream is not recommended, and Gabapentin topical cream is not recommended. Therefore the request for KGCL Cream (Ketamine Hydrochloride) 10/6/0.2/5% 60 mgs is not medically necessary.

**ROBAXIN 500 MG #56 (X3 MONTHS):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain) Page(s): 63-64.

**Decision rationale:** This patient presents with chronic upper extremity pains and the treating physician has been prescribing Robaxin for a number of months or longer. MTUS Guidelines does not support use of muscle relaxants on a long-term basis. Only short-term use is recommended, no more than 2 to 3 weeks at most. Given the chronic use of Robaxin on this patient, which is not supported by MTUS Guidelines, the request for Robaxin 500 mg #56 (x3 months) is not medically necessary.