

<b>Case Number:</b>	CM14-0014792		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	01/30/2002
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	01/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2014

### 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 Anesthesiology, has a subspecialty in Pain Management 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:

The patient is a 48-year-old female who has submitted a claim for reflex sympathetic dystrophy of the upper limb associated with an industrial injury date of January 30, 2002. Medical records from 2013 to 2014 were reviewed. The patient complained of right arm, right elbow and right cervical pain. Pain would extend up from the right upper extremity towards the neck and shoulder. Physical examination showed tenderness over the right paracervical area, right lateral epicondyle and brachioradialis muscle; and swelling of the right thumb and index finger, and right forearm. The diagnosis was repetitive stress disorder of the right upper extremity. Treatment plan includes a request for pain medication refill such as Celebrex, hydrocodone and Voltaren gel. Treatment to date has included oral and topical analgesics, TENS, massage, heat and ice modality and home exercises. A Utilization review from January 24, 2014 denied the requests for one prescription of Celebrex 200mg #30 because there was no indication of osteoarthritis or neuropathic pain; and one prescription of Voltaren gel 1% 300mg due to prolonged use. The request for one prescription of hydrocodone 10/325mg #150 was modified to hydrocodone 10/325mg #120. There was no indication of improved functional capacity as a result of this medication, and the patient was not working. The guideline recommends 20% tapering.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ONE PRESCRIPTION OF CELEBREX 200MG #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 2009: Anti-inflammatory medications; NSAIDs, specific drug list & adverse effects Page(s): 22, 70.

**Decision rationale:** Page 22 of the CA MTUS Chronic Pain Medical Treatment Guidelines states that anti-inflammatories are the traditional first line of treatment to reduce pain, but long-term use may not be warranted. Page 70 recommends that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. In this case, the patient has been on Celebrex as far back as February 2013. However, there was no objective evidence of overall pain and functional improvement derived from its use. The guideline does not recommend long-term use of NSAIDs. There was no compelling rationale concerning the need for variance from the guideline. Therefore, the request for one prescription of Celebrex 200mg #30 is not medically necessary.

**ONE PRESCRIPTION OF HYDROCODONE 10/325MG #150:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 2009: Opioids, criteria for use; On-Going Management Page(s): 78-82.

**Decision rationale:** As noted on pages 78-82 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, the patient has been taking hydrocodone 10/325mg as far back as February 2013. However, there was no objective evidence of continued analgesia and functional improvement from its use. Urine drug screens for monitoring were also not performed. The guideline criteria were not met. There was no compelling rationale for continued use of this medication. Therefore, the request for one prescription of Hydrocodone 10/325MG #150 is not medically necessary.

**ONE PRESCRIPTION OF VOLTAREN GEL 1% 300MG:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 2009: Topical Analgesics (NSAIDs) Page(s): 112.

**Decision rationale:** Page 112 of the CA MTUS Chronic Pain Treatment Guidelines state that Voltaren Gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. In this case, Voltaren gel was used as far back as February 2013. However, there was no objective evidence of overall pain

and functional improvement with its use. There was also no indication of osteoarthritis in this patient. Likewise, there was no evidence of intolerance to oral pain medications that warrant use of topical preparation. The medical necessity has not been established. There was no compelling rationale concerning the need for variance from the guideline. Therefore, the request for one prescription of Voltaren Gel 1% 300MG is not medically necessary.