

<b>Case Number:</b>	CM14-0138046		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	05/09/2001
<b>Decision Date:</b>	10/06/2014	<b>UR Denial Date:</b>	08/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2014

### 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 Occupational Medicine 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:

Patient is a 59 year-old female with date of injury 05/09/2001. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 07/01/2014, lists subjective complaints as pain in the low back. Objective findings: tenderness to palpation of the bilateral sacroiliac joints and left buttocks. No tenderness of lower extremity muscles was noted. A positive straight leg raising test was noted on the left at 60 degrees. Diagnosis: type 2 diabetes, out of control 2. Diabetic peripheral neuropathy, 3. Hypertension, 4. COPD, 5. Sleep apnea, 6. GERD, 7. Elevated cholesterol, 8. Hypertension, 9. Left L4-5 sciatica, 10. Bilateral SI joint pain. The medical records are somewhat sparse, and those supplied for review were insufficient to determine how long the patient has been taking the following medications. No SIG provided. Medications: 1. Voltaren gel 1% 100gm 2. Januvia 100mg, #603. Lyrica 100mg, #604. Tramadol 150mg, #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren gel 1% 100gm with 3 refills:** Upheld

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

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

**Decision rationale:** According to the Official Disability Guidelines, Voltaren gel is not recommended as a first as a first-line treatment, and is recommended only for osteoarthritis after failure of oral NSAIDs, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations. Documentation in the medical record does not meet guideline criteria. This request is not medically necessary.

**Januvia 100mg #60 with 3 refills:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diabetes (Type 1, 2, and Gestational), Sitagliptin (Januvia)

**Decision rationale:** The Official Disability Guidelines state that Januvia is not recommended as a first-line choice. The available medical record contains no documentation that the other first-line choice medications have failed to control the patient's blood sugar. Januvia is not medically necessary.

**Lyrica 100mg #60 with 3 refills:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19-20.

**Decision rationale:** The MTUS states that Lyrica has FDA approval for painful diabetic neuropathy, postherpetic neuralgia, and fibromyalgia. In addition, a recent review has indicated that there is insufficient evidence to recommend for or against antiepileptic drugs for axial low back pain. The patient does carry a diagnosis of diabetic peripheral neuropathy. I am reversing the prior utilization review decision for this request.

**Tramadol 150mg #30 with 3 refills:** Upheld

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

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. The medical record reviewed does not contain documentation showing failure of other first-line oral analgesics, or that the patient gains pain relief and functional improvement by taking tramadol. This request is not medically necessary.