

Case Number:	CM14-0176737		
Date Assigned:	10/30/2014	Date of Injury:	10/30/2011
Decision Date:	12/05/2014	UR Denial Date:	10/15/2014
Priority:	Standard	Application Received:	10/24/2014

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 Preventive 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:

According to the records made available for review, this is a 45-year-old male with a 10/30/11 date of injury. At the time (9/12/14) of the request for authorization for Voltaren 100mg #30 Dispensed 9/12/14, Protonix 20mg #60-Dispensed 9/12/14, and Ultram ER (Tramadol) 150 Mg #60-Dispensed 9/12/14, there is documentation of subjective (modest discomfort involving the right shoulder, some occasional tingling in the hand) and objective (some mild volar wrist swelling is noted with associated tenderness that extends into the pronator tunnel, tenderness over the bicipital groove with slight crepitation noted with active right shoulder range of motion, right shoulder impingement and Hawkins signs are positive. Also, modest residual weakness to grip strength was noted on the right side. The current diagnoses includes history of right carpal tunnel syndrome with ulnar neuropathy, history of right small finger radial collateral ligament disruption at the DIP joint with ganglion cyst, right shoulder tendinopathy, status post right carpal tunnel release with ulnar nerve compression and radial collateral ligament reconstruction of the DIP joint of the right small finger 8/30/12, history of recurrent right carpal tunnel syndrome, and status post redo-decompression of the median nerve within the right carpal tunnel with hypothenar fat pad flap transfer to the carpal tunnel 3/7/13. The treatment to date includes medication of Voltaren and Ultram (for at least 3 months). Medical reports identify a history of non-tolerance to NSAID medication with history of gastritis. Regarding Voltaren 100mg #30 Dispensed 9/12/14, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Voltaren use to date. Regarding Protonix 20mg #60-Dispensed 9/12/14, there is no documentation that Protonix is being used as a second-line. Regarding Ultram ER (Tramadol) 150 Mg #60-Dispensed 9/12/14, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and

there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Ultram use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 100mg #30 Dispensed 9/12/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Diclofenac sodium Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. The MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. The ODG identifies that Diclofenac is not used as first line therapy. Within the medical information available for review, there is documentation of a diagnosis of history of right carpal tunnel syndrome with ulnar neuropathy, history of right small finger radial collateral ligament disruption at the DIP joint with ganglion cyst, right shoulder tendinopathy, status post right carpal tunnel release with ulnar nerve compression and radial collateral ligament reconstruction of the DIP joint of the right small finger 8/30/12, history of recurrent right carpal tunnel syndrome, and status post redo-decompression of the median nerve within the right carpal tunnel with hypothenar fat pad flap transfer to the carpal tunnel 3/7/13. In addition, there is documentation of chronic pain. However, given documentation of treatment with Voltaren for at least 3 months, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Voltaren use to date. Therefore, based on guidelines and a review of the evidence, the request for Voltaren 100mg #30 Dispensed 9/12/14 is not medically necessary.

Protonix 20mg #60-Dispensed 9/12/14: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Proton pump inhibitors (PPIs)

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identifies that risk for gastrointestinal event includes age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; and/or high dose/multiple NSAID. The ODG identifies documentation of risk for gastrointestinal events, preventing gastric ulcers induced by NSAIDs, and that Pantoprazole is being used as a second-line, as criteria necessary to support the medical necessity of Pantoprazole. Within the medical information available for review, there is documentation of diagnoses of history of right carpal tunnel syndrome with ulnar neuropathy, history of right small finger radial collateral ligament disruption at the DIP joint with ganglion cyst, right shoulder tendinopathy, status post right carpal tunnel release with ulnar nerve compression and radial collateral ligament reconstruction of the DIP joint of the right small finger 8/30/12, history of recurrent right carpal tunnel syndrome, and status post redo-decompression of the median nerve within the right carpal tunnel with hypothenar fat pad flap transfer to the carpal tunnel 3/7/13. In addition, given documentation of a history of non-tolerance to NSAID medication with history of gastritis, there is documentation of a risk for gastrointestinal event. However, there is no documentation that Protonix is being used as a second-line. Therefore, based on guidelines and a review of the evidence, the request for Protonix 20mg #60-Dispensed 9/12/14 is not medically necessary.

Ultram ER (Tramadol) 150 Mg #60-Dispensed 9/12/14: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80;113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; as criteria necessary to support the medical necessity of Opioids. In addition, specifically regarding Tramadol, MTUS Chronic Pain Medical Treatment Guideline identifies documentation of moderate to severe pain and Tramadol used as a second-line treatment (alone or in combination with first-line drugs), as criteria necessary to support the medical necessity of Tramadol. The MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of history of right carpal tunnel syndrome with ulnar neuropathy, history of right small finger radial collateral ligament disruption at the DIP joint with ganglion cyst, right shoulder tendinopathy, status post right carpal tunnel release with ulnar nerve compression and radial collateral ligament reconstruction of the DIP joint of the right small finger 8/30/12, history of recurrent right carpal tunnel syndrome, and status post redo-decompression of the median nerve within the right carpal tunnel with hypothenar fat pad flap transfer to the carpal tunnel 3/7/13. In addition, there is

documentation of moderate to severe pain and that Tramadol is being used as a second-line treatment. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given documentation of treatment with Ultram for at least 3 months, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Ultram use to date. Therefore, based on guidelines and a review of the evidence, the request for Ultram ER (Tramadol) 150 Mg #60-Dispensed 9/12/14 is not medically necessary.