

Case Number:	CM14-0089140		
Date Assigned:	09/08/2014	Date of Injury:	07/11/2011
Decision Date:	10/22/2014	UR Denial Date:	06/05/2014
Priority:	Standard	Application Received:	06/13/2014

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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 32 year old female who sustained an industrial injury on 07/11/2011. The mechanism of injury was injuries to both hands and wrists while lifting a patient. Her diagnoses include bilateral wrist and hand pain s/p bilateral wrist surgery in 2012 with a second arthroscopic wrist surgery on the left wrist in 2013. She continues to complain of bilateral wrist pain. Physical examination of the right hand and wrist shows restricted range of motion with tenderness to palpation over the radial side, ulnar side and generalized over the wrist. Examination of the left wrist and hand shows restricted range of motion with tenderness to palpation over the radial side, ulnar side and generalized over the wrist. Treatment in addition to surgery has included medications including opiates and topicals and physical therapy. The treating provider has requested Rozerem 8mg 1 at hs # 30, Voltaren Gel 1 %, and Ultram 50mg 1 qd # 30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Rozerem 8mg Sig. Take 1 at hs #30: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Online Edition, Pain Chapter, Insomnia Treatment

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

Decision rationale: Ramelteon (Rozerem) is a highly selective melatonin receptor type 1 and type 2 agonist,^{1,2} unlike nonprescription melatonin, which is nonselective for all three melatonin receptors.³ The U.S. Food and Drug Administration approved ramelteon 8-mg tablets for the treatment of insomnia characterized by difficulty with sleep onset. Ramelteon has not been compared directly with other hypnotics or melatonin. Ramelteon is safe and effective for decreasing the time to persistent sleep in patients with chronic insomnia. It does not have the potential for abuse or dependence that sedative hypnotics have and is not a controlled substance. No studies have compared Ramelteon with other hypnotics or melatonin, and patient evaluation using postsleep questionnaires has not confirmed consistent benefit. The patient has a chronic pain syndrome with associated insomnia. The medication has proved beneficial. Medical necessity for the requested item has been established. The requested item is medically necessary.

Voltaren 1 percent Gel Sig. Aooly to affected body part 2-3 times PRN (100gm tube) #1:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS; regarding Topical Analgesics.

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

Decision rationale: The documentation indicates that the claimant has chronic hand and wrist pain. She is maintained on medical therapy which includes Tramadol and a topical non-steroidal anti-inflammatory medication, Voltaren Gel 1%. Per California MTUS Guidelines, topical non-steroidal anti-inflammatory medications are used for the treatment of osteoarthritis particularly the knee. There is little evidence that supports them as a treatment option for chronic hand and wrist conditions. The duration of effect is for a period of 4 to 12 weeks with reported diminished effectiveness over time. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Ultram 50mg/tab Sif. take 1 daily PRN #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines (May 2009); regarding C. Decision based on Non-MTUS Citation Official Disability Guidelines, Online Edition, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93, 94-96.

Decision rationale: The review of the medical documentation indicates that the requested medication, Ultram is not medically necessary and indicated for the treatment of the claimant's chronic pain condition. Per California MTUS, Ultram (Tramadol) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain.

The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no documentation of the medication's pain relief effectiveness and no clear documentation that she has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient may require a multidisciplinary evaluation to determine the best approach to treatment of her chronic pain syndrome. Medical necessity for the requested item has not been established. The requested treatment is not medically necessary.