MAXIMUS Federal Services

| Case Number: | CM15-0001990 | | |
|---|---|---|---|
| Date Assigned: | 01/13/2015 | Date of Injury: | 01/05/2000 |
| Decision Date: | 03/16/2015 | UR Denial Date: | 12/02/2014 |
| Priority: | Standard | Application Received: | 01/05/2015 |

## 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

## 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 injured worker is a 68-year-old male who reported an injury on 01/05/2000. The mechanism of injury reportedly occurred while the injured worker was carrying a hose. He was diagnosed with osteoarthritis of the shoulder. Past treatments were noted to include medications, surgery, and epidural steroid injections. On 01/13/2015, the injured worker was seen for medication management as well as for followup for chronic back pain and right radicular symptoms. The injured worker reported 50% improvement in pain with current medication regimen. He indicated his pain was 8/10 without medications. He reported his pain was 4/10 currently. It was also noted the injured worker has tried antidepressants and anticonvulsants to help relieve his pain. He reported he has used Cymbalta and Neurontin. His current medications were noted to include Voltaren 1% topical gel 4 times a day and Vicodin ES 7.5/300 mg every 6 hours as needed. Upon physical examination, he was noted to have symmetrical posture and bilateral lower and upper extremities strength was normal. The treatment plan was noted to include injection to his left shoulder and medications. A request was submitted for 1 prescription of Vicodin ES 7.5mg-300mg and 1 prescription of Voltaren 1% topical gel, however the rationale was not provided. A request for authorization was not submitted.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**1 prescription of Vicodin ES 7.5mg-300mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen; Opioids, criteria for use; Weaning of M.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

**Decision rationale:** The request for 1 prescription of Vicodin ES 7.5mg-300mg is not medically necessary. The California MTUS Guidelines state ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured worker was noted to be on this medication since 2009. The clinical documentation submitted for review does provide evidence of pain relief; however, there is no indication that the opioid helps increase his ability to perform activities of daily living. Additionally, there is a lack of evidence for consistent urine drug screens, verifying appropriate medication use. Based on the documentation provided, use the opioid would not be supported by the guidelines. Furthermore, the request as submitted does not specify a frequency of use. As such, the request is not medically necessary.

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**1 prescription of Voltaren 1% topical gel:** Upheld

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

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

**Decision rationale:** The request for 1 prescription of Voltaren 1% topical gel is not medically necessary. The California MTUS Guidelines state Voltaren gel 1% is FDA approved and is indicated with use for relief in osteoarthritis pain in joints that lend themselves to topical treatment. The injured worker has been on the requested medication since at least 12/2014. In the documentation provided, it was noted the injured worker has osteoarthritis of the shoulder. However, the physician does not provide the rationale indicating why the injured worker would require topical ointment versus oral medication. Additionally, there was no evidence of increased function with use of the medication. Therefore, the request for Voltaren gel is not supported. Furthermore, the request as submitted does not specify a frequency of use. As such, the request for 1 prescription of Voltaren 1% topical gel is not medically necessary.