

Case Number:	CM15-0131753		
Date Assigned:	07/20/2015	Date of Injury:	05/01/2005
Decision Date:	09/09/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/08/2015

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: New York

Certification(s)/Specialty: Internal Medicine

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 45 year old female, who sustained an industrial injury on 05/01/2005. She has reported subsequent right forearm and wrist pain and was diagnosed with forearm tendonitis, radial tunnel syndrome and medial and lateral epicondylitis. Treatment to date has included medication, wrist splints, application of ice and compression sleeve. Documentation shows that Ultram ER, Norco, Cyclobenzaprine and Voltaren gel were prescribed as far back as 12/17/2014. In a progress note dated 06/17/2015, the injured worker complained of continued sharp, constant right forearm and wrist pain that was rated as 5-6/10. Objective findings were notable for diminished sensation in the right arm, pain to palpation over the right extensor tendons and radial wrist and positive Tinel's over the right ulnar wrist. Work status was documented as modified with permanent restrictions. A request for authorization of Ultram ER 200 mg tablets, quantity of 20, Norco 10 mg/325 mg tablets, quantity of 40, Cyclobenzaprine 10 mg tablets, quantity of 30 and Voltaren 1% 100 grams, quantity of 1 was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram ER 200mg tablets, QTY: 20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 93-94, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: According to the California MTUS, 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 analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. The documentation shows that this medication had been prescribed to the injured worker since at least 12/17/2014 and there was no documentation of any significant functional improvement or pain reduction with the use of opioid medication. The physician did not document the intensity of pain after taking Tramadol or the duration of pain relief. There was no documentation of a change in work status and the injured worker's pain was noted to have worsened or remain unchanged from one visit to another. There was no documentation of an improvement with performance of activities of daily living or overall quality of life. In addition, although CURES report was noted to be consistent with prescribed medication, no drug screen results were submitted for review. As per MTUS guidelines opioid medication should be discontinued with no evidence of objective functional improvement unless extenuating circumstances are documented. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. Therefore, the request for authorization of Tramadol is not medically necessary.

Norco 10mg/325mg tablets, QTY: 40: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: According to the CA MTUS, Norco (Hydrocodone/ Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. The documentation shows that this medication had been prescribed to the injured worker since at least 12/17/2014 and there was no documentation of any significant functional improvement or pain reduction with the use of opioid medication. The physician did not document the intensity of pain after taking Norco or the duration of pain relief. There was no documentation of a change in work status and the injured worker's pain was noted to have worsened or remain unchanged from one visit to another. There was no documentation of an improvement with performance of activities of daily living or overall quality of life. In addition, although CURES report was noted to be consistent with prescribed medication, no drug

screen results were submitted for review. As per MTUS guidelines opioid medication should be discontinued with no evidence of objective functional improvement unless extenuating circumstances are documented. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. Therefore, the request for authorization of Norco is not medically necessary.

Cyclobenzaprine 10mg tablets, QTY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: According to CA MTUS guidelines, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. Documentation shows that Cyclobenzaprine had been prescribed to the injured worker since at least 12/17/2014 and there was no documentation of any significant functional improvement or pain reduction with the use of opioid medication. There was no documentation of a change in work status and the injured worker's pain was noted to have worsened or remain unchanged from one visit to another. There was no documentation of an improvement with performance of activities of daily living or overall quality of life. In addition, this medication is not recommended for long term use. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The request for Cyclobenzaprine is not medically necessary.

Voltaren 1% 100grams, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: According to CA MTUS guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Voltaren Gel 1% (Diclofenac) is indicated for the relief of osteoarthritis in joints that lend themselves to topical treatment, such as the ankle, elbow, foot, hand, knee, and wrist. There is no documentation of a failure of first line therapeutic agents. In addition, the documentation shows that this medication had been prescribed to the injured worker since at least 12/17/2014 and there is no evidence of significant pain reduction or objective functional improvement with use. There was no documentation of a change in work status and the injured worker's pain was noted to have worsened or remain unchanged from one visit to another. There was no documentation of an improvement with performance of activities of daily living or overall quality of life. Medical necessity for the requested topical gel has been not established. Voltaren gel is not medically necessary.

