

Case Number:	CM15-0134354		
Date Assigned:	07/22/2015	Date of Injury:	06/06/2012
Decision Date:	08/24/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/11/2015

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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 55-year-old female, who sustained an industrial injury on June 6, 2012, incurring bilateral elbow, forearms, wrist and cervical spine injuries. She was diagnosed with bilateral carpal tunnel syndrome, cervical disc bulging and cervical stenosis, lateral epicondylitis, synovitis, degenerative osteoarthritis of the left hand and a degenerative tear in the left wrist. Treatment included physical therapy, epidural steroid injection, pain medications, topical analgesic gels, and work restrictions. Currently, the injured worker complained of persistent pain with swelling in her hand and elbow. She noted worsening recurring trigger finger like symptoms in the left hand. The treatment plan that was requested for authorization included prescriptions for Ultracet and Voltaren Gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultracet 37.5/325mg tablets QTY: 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol, Ultram Page(s): 74-96, 113, 123. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Medications for acute pain (analgesics), Tramadol (Ultram®).

Decision rationale: Ultracet is the brand name version of Tramadol and Tylenol. MTUS refers to Tramadol/Tylenol in the context of opioids usage for osteoarthritis "Short-term use: Recommended on a trial basis for short-term use after there has been evidence of failure of first-line non-pharmacologic and medication options (such as acetaminophen or NSAIDs) and when there is evidence of moderate to severe pain. Also recommended for a trial if there is evidence of contraindications for use of first-line medications. Weak opioids should be considered at initiation of treatment with this class of drugs (such as Tramadol, Tramadol/acetaminophen, hydrocodone and codeine), and stronger opioids are only recommended for treatment of severe pain under exceptional circumstances (oxycodone, oxycodone, hydromorphone, fentanyl, morphine sulfate)." MTUS states regarding tramadol that "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." ODG further states, "Tramadol is not recommended as a first-line oral analgesic because of its inferior efficacy to a combination of Hydrocodone/ acetaminophen." The treating physician did not provide sufficient documentation that the patient has failed a trial of non-opioid analgesics at the time of prescription or in subsequent medical notes. Additionally, no documentation was provided which discussed the setting of goals for the use of tramadol prior to the initiation of this medication. The medical notes do not indicate any improved objective/subjective findings over that duration of time. As such, the request for Ultracet 37.5/325mg tablets QTY: 120 is not medically necessary.

Voltaren 1% Gel 100GM Tubes QTY: 15: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional improvement, Topical Analgesics Page(s): 48, 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: MTUS and ODG recommend usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." VOLTAREN (DICLOFENAC) (RECOMMENDED FOR OA). MTUS specifically states for Voltaren Gel 1% (diclofenac) that it is "Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder." Medical records do indicate that the patient is being treated for osteoarthritis pain in the joints. The records indicate that the treatment area would be for the hand and wrist. As such, the request for Voltaren 1% Gel 100gm Tubes QTY: 15 is medically necessary.