MAXIMUS Federal Services

Case Number:	CM15-0010206		
Date Assigned:	01/27/2015	Date of Injury:	07/29/2013
Decision Date:	03/17/2015	UR Denial Date:	12/18/2014
Priority:	Standard	Application Received:	01/16/2015

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
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 54 year old female, who sustained a work/ industrial injury as a waitress on 7/29/13. She has reported symptoms of pain in the bilateral upper extremities (left shoulder, right elbow, bilateral hands). The diagnoses have included tendinitis of the wrist. On 12/10/14, the physician noted complaints of pain in the bilateral upper extremities with no response to acupuncture. The exam revealed tender right wrist, Finkelsteins, left shoulder decreased range of motion and impingement signs: right elbow tender lateral epicondyle. Treatment to date has included oral and topical medication and acupuncture. The Magnetic Resonance Imaging (MRI) of the right elbow noted mild tendinosis of both the common extensor and common flexor tendons, low grade strain of the distal brachialis muscle, increased T2 signal in the ulnar nerve proximal to the cubital tunnel. The physician ordered Ultracet and Voltaren gel for pain relief. On 12/18/14, Utilization Review non-certified Ultracet 37.5/325 mg #40 (every 12 hours prn pain) and Voltaren Gel 1%, noting the Medical treatment Utilization Schedule (MTUS) Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultracet 37.5/325, #40 (q 12 hours PRN pain): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

Decision rationale: Ultracet 37.5/325, #40 (q 12 hours PRN pain) is not medically necessary per the MTUS Guidelines. There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, random drug testing, opioid contract. The MTUS Chronic Pain Medical Treatment Guidelines state that a pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The documentation does not indicate evidence of the above prescribing guidelines therefore the request for Ultracet is not medically necessary.

Voltaren gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel 1% (diclofenac).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics - Voltaren Gel Page(s): 112.

Decision rationale: Voltaren Gel is not medically necessary per the MTUS Guidelines. The MTUS states that Voltaren Gel 1% (diclofenac) 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. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The request as written does not indicate a strength or quantity for the Voltaren Gel. The request does not indicate which body part this is for. Without this information the request for Voltaren gel cannot be certified and is not medically necessary.