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| <b>Case Number:</b>   | CM15-0018533 |                              |            |
| <b>Date Assigned:</b> | 02/06/2015   | <b>Date of Injury:</b>       | 05/03/2013 |
| <b>Decision Date:</b> | 05/28/2015   | <b>UR Denial Date:</b>       | 12/29/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/31/2015 |

### 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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 58-year-old female who sustained an industrial injury on 05/30/2013. Prior treatment to include: completed 13-session therapy/rehabilitation. The injured worker is status post left thumb basal joint resection arthroplasty 06/18/2014 with recommendation for an interferential unit. The current diagnoses include history of left first dorsal compartment decompression, history of persistent left wrist tendinopathy, neuroma of the distal branch of the left lateral antebrachial cutaneous nerve, history of left thumb basal joint arthropathy, and status post left thumb basal joint resection arthroplasty. The injured worker presented on 04/09/2015 for a follow-up evaluation. It was noted that the injured worker had completed additional physical therapy and continued to participate in a home exercise program. The injured worker expressed concern about substantial persistent pain and weakness affecting the left thumb. The current medication regimen includes Zoloft, levothyroxine, and lorazepam. Upon examination, there was localized swelling and crepitation directly over the flexor sheath of the left thumb. There was no active triggering or tenderness noted. Treatment recommendations included a prescription for Voltaren, Protonix, and Tylenol No. 3. The injured worker was instructed to continue with a home based exercise program. An interferential unit was also recommended. A Request for Authorization form was then submitted on 04/09/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325Mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the only clinical documentation submitted for review is the physician progress note dated 04/09/2015. The injured worker's medication regimen does not include the above requested medication. There is no indication that this injured worker is currently utilizing the above medication. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

**Retrospective Ultram ER 150Mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute, ODG Treatment in Workers Compensation, 7th edition, 2011.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the only clinical documentation submitted for review is the physician progress note dated 04/09/2015. The injured worker's medication regimen does not include the above requested medication. There is no indication that this injured worker is currently utilizing the above medication. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

**Retrospective Protonix 20Mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?sefidoo08098cb2-c048-4640-f387-6beec4o38936>.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** California MTUS Guidelines state, proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. Additionally, there is no frequency listed in the request. As such, the request is not medically appropriate.

**Voltaren 100Mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbates of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. In this case, there was no documentation of an acute exacerbation of chronic pain. Guidelines do not support long-term use of NSAIDs. There is no frequency listed in the request. Given the above, the request is not medically necessary.