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| Case Number: | CM15-0018706 | | |
| Date Assigned: | 02/06/2015 | Date of Injury: | 09/14/2012 |
| Decision Date: | 04/14/2015 | UR Denial Date: | 01/23/2015 |
| Priority: | Standard | Application Received: | 02/02/2015 |

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, Arizona
 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 49-year-old female who reported an injury on 09/14/2012, after moving a patient, which reportedly caused a twisting motion to her right elbow and right wrist. The injured worker's diagnoses included cubital tunnel syndrome and carpal tunnel syndrome of the right upper extremity. The injured worker's treatment history included medications, activity modification, physical therapy, and cognitive behavioral therapy. The injured worker was evaluated on 10/27/2014. It was noted that the injured worker had improvements in range of motion but had continued pain complaints. Objective findings included weakness and swelling in the right wrist and elbow. It was noted that x-rays were taken and no evidence of osteoarthritis was noted on the imaging study. The injured worker's medications were noted to be hydrocodone/APAP 10/325 mg, orphenadrine citrate ER 100 mg, diclofenac sodium ER 100 mg, tramadol hydrochloride ER 150 mg, and pantoprazole sodium ER 20 mg #60. The injured worker's treatment plan included continuation of medications, a home exercise program, continuation of bracing, and alternation between heat and ice therapy. No justification for the current request was provided. No Request for Authorization form was submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine 50mg/Caffeine 10mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS

<http://www.ncbi.nlm.nih.gov/pubmed/22656684> rev bras Anesthesiol, 2012 May-Jun; 62 (3):387-401. doi: 10.1016/s0034-7094(12) 70139-3, Caffeine in the Treatment of Pain Tavares CL, Sakata RK <http://www.ncbi.nlm.nih.gov/pubmed/22656684>.

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

Decision rationale: The requested orphenadrine 50 mg/caffeine 100 mg #60 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends short-term use of muscle relaxants to assist with acute exacerbations of chronic pain. The clinical documentation indicates that the injured worker has been on this medication since at least 02/2013. This is well in excess of guideline recommendations. Additionally, the clinical documentation does not provide an adequate assessment of the injured worker's pain relief or functional benefit resulting from the use of this medication. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of use. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested orphenadrine 50 mg/caffeine 10 mg #60 is not medically necessary or appropriate

Kera Tek gel #113: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals Page(s): 105.

Decision rationale: The requested Kera Tek gel #113, is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend the use of topical salicylates. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended period of time. However, the clinical documentation fails to provide an adequate pain assessment to establish efficacy of this medication. Additionally, there is no documentation of functional improvement. Therefore, continued use of this medication would not be supported in this clinical situation. Furthermore, the request as it is submitted does not clearly identify a frequency of use or applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Kera Tek gel #113 is not medically necessary or appropriate.

Gabapentin/Pyridoxine 250mg/10mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs (AEDs) Page(s): 16-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Chapter, Vitamin B.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16.

Decision rationale: The requested gabapentin/pyridoxine 250 mg/10 mg is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend the use of anticonvulsants as a first line medication in the management of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 02/2013. However, continued use should be based on documented functional benefit and evidence of pain relief. The clinical documentation does not provide an adequate assessment of the injured worker's pain relief, or establish functional benefit resulting from medication usage. Additionally, the request as it is submitted does not provide a quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested gabapentin/pyridoxine 250 mg/10 mg is not medically necessary or appropriate.