

Case Number:	CM15-0127078		
Date Assigned:	07/13/2015	Date of Injury:	05/15/2005
Decision Date:	09/16/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	07/01/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 67-year-old female, who sustained an industrial injury on May 15, 2006. She reported a gradual onset of right shoulder pain and right upper extremity pain secondary to repetitive strain injury. The injured worker was diagnosed as having carpal tunnel syndrome, long term use of medications, pain in hand joint, pain in shoulder joint, cervicobrachial syndrome, right shoulder rotator cuff injury with tendinosis, bursitis and partial tear of the supraspinatus tendon, right shoulder adhesive capsulitis, right thumb trigger finger, right wrist tendinitis, compensable left shoulder rotator cuff injury, repetitive strain injury of both upper extremities and subclinical bilateral carpal tunnel syndrome. Treatment to date has included diagnostic studies, left shoulder cortisone injection, exercises, physical therapy, topical medication and oral medications. On June 30, 2015, the injured worker complained of severe pain in the left thumb that worsened with pincer grasping and gripping. She continued to have occasional bilateral shoulder pain at times. If her pain did increase in level, she rated it as a 3-4 on a 1-10 pain scale. She also reported occasional pain into the left upper back and trapezius. She reported improved pain control and function with usage of Relafen and Ultracet. A left shoulder cortisone injection provided only minimal benefits and the physical therapy was noted to not be very helpful. The treatment plan included medication and a follow-up visit. On June 4, 2015, Utilization Review non-certified the request for Diclofenac Sodium 1.5% Cream 60 gm quantity 2 and Ketamine 5% Cream 60 gr quantity 2, citing the Official Disability Guidelines. A request for Nabumetone-Relafen 500 mg #90 quantity 180, Tramadol/Apap 37.5/325 mg #90 quantity

180 and Voltaren 1% Gel quantity 3 was modified to Nabumetone-Relafen 500 mg #90 quantity 120, Tramadol/Apap 37.5/325 mg #90 quantity 120 and Voltaren 1% Gel quantity 2, citing California MTUS Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nebumeton-Relafen 500mg #90 Qty 180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs; Relafen Page(s): 67- 72. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, NSAIDs.

Decision rationale: MTUS and ODG state regarding NSAIDs for osteoarthritis, "Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy." For acute back pain, "Recommended as a second-line treatment after acetaminophen." For chronic back pain, "Recommended as an option for short-term symptomatic relief." For neuropathic pain, "There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain." MTUS states "Nabumetone (Relafen, generic available): 500, 750 mg. Dosing: Osteoarthritis: The recommended starting dose is 1000 mg PO. The dose can be divided into 500 mg PO twice a day. Additional relief may be obtained with a dose of 1500 mg to 2000 mg per day. The maximum dose is 2000 mg/day. Patients weighing less than 50 kg may be less likely to require doses greater than 1000 mg/day. The lowest effective dose of nabumetone should be sought for each patient. Use for moderate pain is off-label. (Relafen Package Insert)" Guidelines state that Tylenol is preferred in many cases as first line. Medical records do not indicate any significant improvement in pain, quality of life, or functionality. The patient has been prescribed Relafen since in excess of guideline recommendations of short-term therapy. The treating physician has not provided justification to exceed MTUS guidelines. As such, the request for Nebumetone-Relafen 500mg #90 Qty 180 is not medically necessary.

Tramadol/APAP 37.5/325mg #90 Qty 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines on-going management of 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: Ultram is the brand name version of Tramadol, which is classified as central acting synthetic opioids. MTUS states regarding Tramadol "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." No documentation was provided which discussed the setting of goals for the use of Tramadol prior to the initiation of this medication. The patient has been prescribed Tramadol since 2/22/2010. Submitted medical records do not document evidence of functional improvement. The original utilization review modified the request to Tramadol/APAP 37.5/325mg #90 Qty 120. As such, the request for Tramadol/APAP 37.5/325mg #90 Qty 180 is not medically necessary.

Voltaren Gel 1% Qty 3 refills 3: Upheld

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

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." 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." 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 indicate the patient has been prescribed Voltaren Gel since 7/24/2008. The records indicate that the treatment area would be for the hand joint, however there does not appear to be a diagnosis of osteoarthritis. Additionally, the medical records provided indicate Voltaren has been discontinued. As such, the request for Voltaren Gel 1% Qty 3 refills 3 is not medically necessary.

Diclofenac Sodium 1.5% cream 60gm Qty 2: Upheld

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

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 (Chronic), Pennsaid, Topical Analgesics.

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." ODG states regarding Pennsaid, "Not recommended as a first-line treatment. See the Diclofenac Sodium listing, where topical Diclofenac is recommended for osteoarthritis after failure of an oral NSAID or contraindications to oral NSAIDs, and after

considering the increased risk profile with Diclofenac, including topical formulations." The treating physician does not detail any failure or contraindication of oral NSAIDs. As such, the request for Diclofenac Sodium 1.5% cream 60gm Qty 2 is not medically necessary.

Ketamine 5% cream 60gr Qty 2: Upheld

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

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." MTUS states regarding topical Ketamine, "Under study: Only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted." Medical records do not indicate that all primary and secondary treatment options have been exhausted. As such, the request for Ketamine 5% cream 60gm Qty 2 is not medically necessary.