

Case Number:	CM15-0170406		
Date Assigned:	09/10/2015	Date of Injury:	06/14/2011
Decision Date:	10/15/2015	UR Denial Date:	07/29/2015
Priority:	Standard	Application Received:	08/28/2015

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, Hawaii
 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 58 year old male, who sustained an industrial injury on 6-14-2011. Diagnoses include chronic right wrist and hand pain status post right wrist surgery (1-03-2012), chronic right shoulder pain with full thickness component and partial tear of the supraspinatus tendon per magnetic resonance imaging (MRI) dated 4-13-2012, chronic right lateral epicondylitis and medial epicondylitis, insomnia secondary to pain, chronic right thumb pain with limitation of range of motion and chronic right leg radicular symptoms with numbness of the right leg with unknown etiology. Treatment to date has included surgical intervention (right wrist, 2012), as well as conservative measures including diagnostics, work modification, medications, and physical therapy. Per the Primary Treating Physician's Progress Report dated 6-23-2015, the injured worker reported right shoulder, right elbow, right hand, right wrist and right thumb pain. He also has neck pain to date. He is finally going to the hospital because he is very dizzy. Objective findings included tenderness of the right thumb and right wrist with right medial and lateral epicondylar tenderness. There was right forearm and upper arm tenderness. There was right shoulder rotator cuff, infraspinatus and supraspinatus tenderness. There was paracervical tenderness noted from C2 to C7-T1 and right parathoracic tenderness from T1-T7. Per the medical records the injured worker has been prescribed Tramadol and Voltaren gel since at least 9-19-2014. He reports pain relief and improved functioning from the Tramadol with no significant side effects. Authorization was requested for Elavil 25mg #30, Voltaren gel 1% #5, and Tramadol 50mg #120. On 7-29-2015, Utilization Review non-certified the request for Elavil 25mg #30, Voltaren gel 1% #5 and Tramadol 50mg #120 citing lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Elavil 25mg #30, Refill: 3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter - Antidepressants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain.

Decision rationale: The patient has ongoing complaints of neck pain, right shoulder, right elbow, right hand, right wrist and right thumb pain. The current request is for Elavil 25mg #30, Refill: 3. The attending physician offers no discussion as to why he has recommended Elavil. The CA MTUS recommends tricyclic antidepressants for neuropathic pain. For non-neuropathic pain, tricyclic antidepressants are recommended as an option for depressed patients. In this case, the patient has non-neuropathic pain and the medical records offer no discussion of depression. As such, the medical records do not establish medical necessity for Amitriptyline and therefore is not medically necessary.

Voltaren gel 1% 5-100g tubes, Refill: 3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The patient has ongoing complaints of neck pain, right shoulder, right elbow, right hand, right wrist and right thumb pain. The current request is for Voltaren Gel 1% 5-100g tubes, Refill: 3. The attending physician report dated 6/23/15 indicates that the Voltaren Gel is for the joints of the upper extremity. The CA MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed; these agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). 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. With regards specifically to Voltaren Gel 1% (diclofenac): 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. In this case, the records fail to discuss the diagnoses of osteoarthritis of the ankle, elbow, foot, hand, knee or wrist. As such, the medical records are inconsistent with the CA MTUS guidelines and do not establish medical necessity for the request of Voltaren Gel and therefore is not medically necessary.

Tramadol 50mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The patient has ongoing complaints of neck pain, right shoulder, right elbow, right hand, right wrist and right thumb pain. The current request is for Tramadol 50mg #120. The attending physician recommends Tramadol for increased functional ability and decreased pain. According to the MTUS guidelines, four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids. The domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, while there is clear documentation of pain, there is no documentation of how the Tramadol is decreasing the patient's baseline pain and no pain assessment is noted in the documents made available for review. There is also no documentation of improved functional ability or return to work in the records made available for review. The CA MTUS require far more documentation for ongoing opiate management. As such, the medical records do not establish medical necessity for the request and therefore is not medically necessary.