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| Case Number: | CM15-0061174 | | |
| Date Assigned: | 04/07/2015 | Date of Injury: | 03/11/2002 |
| Decision Date: | 05/28/2015 | UR Denial Date: | 03/26/2015 |
| Priority: | Standard | Application Received: | 03/31/2015 |

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 62 year old female, who sustained an industrial injury on 03/11/2002. The mechanism of injury was not provided for review. The injured worker was diagnosed as having tenosynovitis of the right hand/wrist and right rotator cuff sprain and tendon bursae disorder. There is no record of a recent diagnostic study. Treatment to date has included physical therapy, exercises, heat and medication management. In a progress note dated 03/10/2015, the injured worker complains of pain in the right shoulder, right wrist and neck. Upon examination, there was 4/5 motor strength in the right upper extremity with improved right shoulder range of motion to greater than 90 degrees flexion. There was mild to moderate tenderness to palpation over the right AC joint and severe tenderness to palpation over the palmar aspect of the bilateral wrist. The injured worker utilized bilateral soft wrist braces. Treatment recommendations at that included continuation of the current medication regimen. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg quantity 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80-82; 76-80.

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 nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the injured worker has continuously utilized the above medication since at least 11/2014. There is no documentation of objective functional improvement. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Lidoderm patch: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines recommend lidocaine for localized peripheral pain or neuropathic pain after there has been evidence of a trial of first line therapy with tricyclic or SNRI antidepressants or an anticonvulsant. In this case, there is no documentation of a failure to respond to first line therapy. There is also no strength, frequency, or quantity listed in the request. Given the above, the request is not medically necessary.

Voltaren Gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state the only FDA approved topical NSAID is diclofenac 1% gel, which is indicated for the relief of osteoarthritis pain. The injured worker does not maintain a diagnosis of osteoarthritis. There is also no strength, frequency, or quantity listed in the request. Given the above, the request is not medically necessary.

Tramadol 50mg quantity 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80-82; 76-80.

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 nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the injured worker has continuously utilized the above medication since at least 11/2014. There is no documentation of objective functional improvement. There is also no frequency listed in the request. Given the above, the request is not medically necessary.