

<b>Case Number:</b>	CM15-0062457		
<b>Date Assigned:</b>	04/08/2015	<b>Date of Injury:</b>	11/22/2010
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	03/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2015

### 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

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 41 year old female who sustained a work related injury November 22, 2010. The mechanism of injury was not provided. According to a treating orthopedic physician's notes, dated March 6, 2015, the injured worker presented for re-evaluation of her right forearm and right hand. She has tenderness along the carpal tunnel, CMC (carpometacarpal joints) and first extensor. Otherwise, she has full range of motion and full strength to resisted function. She is awaiting a report from a qualified medical evaluator to release her to work. Diagnosis is documented as wrist joint inflammation on the right and non-specific discomfort along the hand including the thenar area and the base of the thumb on the right. Treatment plan included requests for authorization for Norco, Tramadol, Cyclobenzaprine, Voltaren Gel and TENS unit with conductive garment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol ER 150mg #30 (per 03/06/15 order): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91, 93-94, 78-80, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California MTUS Guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Tramadol ER 150mg #30 (per 03/06/15 order) is not medically necessary.

**Norco 10/325mg #120 (per 03/06/15 order): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91, 93-94, 78-80, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California MTUS Guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Norco 10/325mg #120 (per 03/06/15 order) is not medically necessary.

**Cyclobenzaprine 7.5mg #60 (per 03/06/15 order): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anispasmodics Page(s): 64.

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

**Decision rationale:** The California MTUS Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain, less than 3 weeks and there should be documentation of objective functional improvement. The clinical documentation submitted for review failed to provide documentation the injured worker had objective findings of muscle spasms during the examination. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for cyclobenzaprine 7.5 mg #60 (per 03/06/2015 order) is not medically necessary.

**Voltaren Gel 1% Qty: 1 (per 03/06/15 order): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 112.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that Voltaren Gel 1% (diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The clinical documentation submitted for review failed to indicate the injured worker had osteoarthritis. The request as submitted failed to indicate the body part and frequency to support the use of the requested medication. Given the above, the request for Voltaren Gel 1% Qty: 1 (per 03/06/15 order) is not medically necessary.