

<b>Case Number:</b>	CM13-0037243		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	07/13/2013
<b>Decision Date:</b>	02/11/2014	<b>UR Denial Date:</b>	09/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/27/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Plastic and Reconstructive Surgery and is licensed to practice in Maryland, North Carolina and Virginia. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 48-year-old right-hand dominant male who works as a carpenter, with a reported work-related date of injury on 7/13/13. He had amputation of his left index finger at the proximal third of the middle phalanx, while using a skill saw cutting wood. He was initially seen by medical personnel that day, but had definitive surgical treatment 2 days later. Operative note from that day indicate Left index finger, irrigation and debridement, exploration of wound, rongeur of middle phalanx, exploration under fluoroscopy, delayed primary closure with rotational advancement flaps. The patient was noted to have been prescribed Cephalexin 500 mg with qty. of 28. On 7/26/13, the patient is noted to begin initial hand therapy and tip protection with splint. At that time, he was noted to have pain, decreased range-of-motion and weakness. Diagnosis code selected was 885.1, which defines a complicated amputation of the thumb. On 8/7/13 follow-up, he was noted to have neuropathic pain to the left index finger and discussed the use of Gabapentin. He was also noted to be depressed and anxious due to loss of the finger. He was placed on modified duty at work with no use of the left hand beginning July 24, 2013. On 9/26/13 follow-up, the patient was noted to have 'ongoing pain, swelling, stiffness and hypersensitivity' of the left index finger. He has attempted home exercise program. The pain in his finger affects his sleep as does his anxiety and depression. Examination notes the stump is swollen, marked hypersensitivity that has improved and active range-of-motion is absent at the PIP and decreased at the MCP. Requests were made for authorization of additional hand therapy, psychiatric evaluation and medications. Specific medication request included Anaprox(Naproxen) 550 mg PO BID qty 60 an NSAID to reduce pain and swelling, Gabapentin 600 mg PO BID qty 60 for neuropathic pain due to nerve damage and Remeron 15 mg PO QHS qty 30 for sleep as patient has f

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Decision for Cefprozil 500mg, #1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Infectious Diseases, Approach to Evaluation; Bone and Joint Infections: osteomyelitis, acute; Skin and Soft tissue infections: abscess, cellulitis.

**Decision rationale:** The Physician Reviewer's decision rationale: The patient had a complex amputation of the left index finger, which required a completion amputation 2 days later. The patient was initially placed on a 1st generation Cephalosporin at the time of the injury/completion amputation. In follow-up, there was minimal documentation to support that the patient had a cellulitis (infection of the skin) or acute osteomyelitis (infection of the bone) to necessitate further treatment with antibiotics. The only evidence for infection was stated as pain. The examination did not note any erythema, purulence, diagnostic studies or other evidence to suggest infection. Based on the ODG Infectious Diseases as reasoned in the utilization review, there are indications for treatment of different types of infection. However, a diagnosis of infection is necessary. As stated in the utilization review, there is not sufficient documentation that an infection is present and thus I would agree with the determination.

### **Decision for Gabapentin 100mg, qty 1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatment Page(s): 19, 49.

**Decision rationale:** The Physician Reviewer's decision rationale: As reasoned below and restated here, the patient is well documented to complain of chronic pain associated with the traumatic amputation and later completion amputation. The request had been denied because attempt at clarifying the quantity of medication was unsuccessful. Based on the level of documentation, the patient has neuropathic pain that is consistent with the history and physical examination. Specifically, from Chronic Pain Medical treatment guidelines, Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. Gabapentin has a favorable side-effect profile, few clinically significant drug-drug interactions and is generally well tolerated; however, common side effects include dizziness, somnolence, confusion, ataxia, peripheral edema, and dry mouth. (Eisenberg, 2007) (Attal, 2006) Thus, it is reasonable to treat the patient with Gabapentin for his well-documented neuropathic pain. Specific dosing for traumatic amputation induced

neuropathic pain is not provided. It is not clear why a request for 100 mg of Gabapentin was made. However, a 600 mg does appears to be the correct dosing requested as documented in the medical record on later examinations. Thus, I support that the request for 100 mg is not certified.

**Decision for Gabapentin 600mg, qty 1: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatment Page(s): 19, 49.

**Decision rationale:** The patient is well documented to complain of chronic pain associated with the traumatic amputation and later completion amputation. The request had been denied because attempt at clarifying the quantity of medication was unsuccessful. Based on the level of documentation, the patient has neuropathic pain that is consistent with the history and physical examination. Specifically, from Chronic Pain Medical treatment guidelines, Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. Gabapentin has a favorable side-effect profile, few clinically significant drug-drug interactions and is generally well tolerated; however, common side effects include dizziness, somnolence, confusion, ataxia, peripheral edema, and dry mouth. (Eisenberg, 2007) (Attal, 2006) Thus, it is reasonable to treat the patient with Gabapentin for his well-documented neuropathic pain. Specific dosing for traumatic amputation induced neuropathic pain is not provided. However, dosage may be increased as needed up to a total daily dosage of 1800 mg in three divided doses. Doses above 1800 mg/day have not demonstrated an additional benefit in clinical studies. (Neurontin package insert). Even though the earlier dated medical record is unclear with respect to the dosing, the physician later states a request for 600 mg and quantity of 60. Thus, it is reasonable to certify a dose of 600 mg.