

<b>Case Number:</b>	CM13-0040415		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	08/24/2012
<b>Decision Date:</b>	05/22/2014	<b>UR Denial Date:</b>	09/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/10/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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/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 41 year old female who had a work injury dated 8/24/12. Her diagnoses include right ankle and foot pain with numbness and tingling, plantar fasciitis, neuroma, possible cuboid syndrome. There are requests for Mentherm 120 ml, Acetadryl 500mg #50, and Topiramate 50mg #60 two refills. A 9/19/13 primary treating physician progress report states that the patient came to the office for therapeutic ultrasound for right foot pain which is 7/10, constant and burning. The patient has approval for physical therapy and orthotics. The physical exam revealed an antalgic gait with full range of motion in the right ankle and tenderness to palpation in the right ankle and foot. There is decreased sensation in the right foot. The treatment plan was to continue the Topiramate and Mentherm. The patient tolerates the ultrasound well and the pain came down to 6/10. A 10/8/13 podiatry follow up indicates that the patient states she is improving with her home exercise and therapy sessions. She is working, standing and making sandwiches all day. She Final Determination Letter for IMR Case Number CM13-0040415 3 does rest, ice compression, and elevation. On physical exam her orthotics fit well. All vascular, neurological, dermatological, and musculoskeletal findings are unchanged since last visit. She has a positive Mulder's sign, right foot, and third intermetatarsal space. She has pain to palpation of the right third intermetatarsal space and pain to palpation of the right cuboid. She has pain with palpation of the right plantar medial arch and the heel. She has pain with palpation of the right foot first metatarsophalangeal joint. The provider cannot dorsiflex the joint without causing pain. There is no crepitus with range of motion. According to the podiatrist there is also pain with palpation of that area, but x-rays are showing completely normal foot. There is evidence of fracture or abnormalities. X-rays and MRI show that the patient has a thickened plantar fascia on the MRI and increased signal intensity consistent with plantar fasciitis. X-rays show completely

normal findings. There is no fracture of her right foot. MRI from August 23, 2013, shows no acute fracture or dislocation, joint spaces are normal bone mineralization is unremarkable. There is no osteolysis or osteosclerosis. There is an 8/9/13 medical status report that states that patient had an abnormal score on an Epworth sleepiness scale. She was given education on sleep hygiene and started on Acetadryl.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**ACETADRYL 500MG #50:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ACETAMINOPHEN (APAP), Page(s): 11-12.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ACETAMINOPHEN (APAP) NSAIDS Page(s): 11. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic pain:Insomnia; and Acetadryl drug package insert.

**Decision rationale:** The MTUS guidelines are silent on insomnia and specifically Acetadryl but do address an ingredient of Acetadryl which is Acetaminophen. The Official Disability Guidelines (ODG) does not address Acetadryl but does discuss insomnia treatment and an ingredient in Acetadryl which is Benadryl. The Acetadryl drug package insert indicates that this medication contains Benadryl and Tylenol. The documentation indicates that the patient was given this medication for sleep along with information on sleep hygiene. Benadryl is considered a sedating antihistamine. The ODG states that sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Side effects include urinary retention, blurred vision, orthostatic hypotension, dizziness, palpitations, increased liver enzymes, drowsiness, dizziness, grogginess and tiredness. The ODG states that pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; and (d) Next-day functioning. Acetaminophen is recommended for treatment of chronic pain and acute exacerbations of chronic pain per the MTUS guidelines. The documentation submitted does not reveal that patient has attempted any sleep hygiene practices prior to initiating pharmacological aids. There is no specific discussion of the specific component of insomnia in the documentation submitted. There is no indication from documentation that for pain the patient cannot take Acetaminophen alone without the diphenhydramine component which itself can cause side effects of tiredness and grogginess per the ODG guidelines and package insert. The request for Acetadryl 500mg #50 is not medically necessary and appropriate.

**TOPIRAMATE 50MG, #60, X 2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPIRAMATE (TOPAMAX (R), NO GENERIC AVAILABLE) Page(s): 21.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OTHER EPILEPTIC DRUGS Page(s): 27. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OTHER EPILEPTIC DRUGS, 27.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines states that Topiramate has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. The documentation submitted does not reveal evidence that the patient has failed other anticonvulsants for neuropathic pain. There is a 5/9/13 document stating that the provider will start Gralise for neuropathic pain. A 7/26/13 document indicates that a trial of Topiramate will be started. A document dated 8/13/13 states that the patient is taking Gralise. The documentation does not indicate that the patient failed Gralise or why two antiepileptic medications were necessary. The request for Topiramate 50mg #60, 2 refills is not medically necessary and appropriate.

**MENTHODERM 120ML:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SALICYLATE TOPICALS; TOPICAL ANALGESICS; TOPICAL ANALGESICS Compounded, page 105.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SALICYLATE TOPICALS AND TOPICAL ANALGESICS Page(s): 105, 111-113.

**Decision rationale:** The MTUS guidelines states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The documentation does not indicate intolerance to oral medications. The request for Menthoderm 120ml is not medically necessary and appropriate.