MAXIMUS Federal Services

| Case Number: | CM14-0002636 | | |
|---|---|---|---|
| Date Assigned: | 01/29/2014 | Date of Injury: | 07/19/2006 |
| Decision Date: | 06/16/2014 | UR Denial Date: | 12/27/2013 |
| Priority: | Standard | Application Received: | 01/07/2014 |

## 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California and Nevada. 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 injured worker is a 53 year old male injured on 07/16/06 when he sustained a maceration injury to the left ring finger while using an electric saw. Current diagnoses included major depressive affective disorder, post Maddox stress disorder, chronic pain, pain in limb, disturbance of skin sensation, and crushing injury of the hand. The patient presented with upper extremities pain, allodynia, hyperpathia in the upper extremities, and at amputation site. The patient's medications included Voltaren gel, Neurontin 300mg QAM to QPM, Norco 10/325mg two to three QD, Butrans 5mcg Q seven days.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**BUTRANS 5MCG/HR #4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

**Decision rationale:** As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear

documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Butrans 5MCG/HR #4 cannot be established at this time.

**VOLTAREN 1% GEL WITH 1 REFILL:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Page(s): 111.

**Decision rationale:** As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, VoltarenÂ® Gel 1% (diclofenac) is 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. There is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. As such, Voltaren 1% gel with 1 refill cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

**REPEAT LEFT STELLATE GANGLION BLOCK INJECTION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Regional Sympathetic Blocks (Stellate Ganglion Block, Thoracic Sym.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), CRPS, Sympathetic Blocks (therapeutic).

**Decision rationale:** Based on current evidence based guidelines, clinical documentation lacked evaluation and fulfilment of Budapest (harden) criteria. The patient complained of allodynia and hyperpathia. There was no additional physical examination findings provided establishing the presence of CRPS. Additionally, it was noted the was being requested repeat left stellate ganglion blocks injection; however, there was no documentatoin of the response to the initial stellate ganglion blocks to establish the appropriateness of repeat injections. As such, the request for repeat left stellate ganglion blocks injection cannot not be recommended as medically necessary.

**NORCO 10/325MG #90 WITH 1 REFILL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, Page(s): 76-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

**Decision rationale:** As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Norco 10/325mg #90 with 1 refill cannot be established at this time.