

<b>Case Number:</b>	CM14-0029128		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	07/09/2007
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	02/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/07/2014

### 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 Physical Medicine & Rehabilitation, and is licensed to practice in California. 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 29-year-old female who reported an injury on 07/09/2007. The mechanism of injury was from repetitive office type work. Her current diagnoses include pain in joint of the upper arm and pain in joint of the hand and forearm. Previous treatments include medications, home exercise program and physical therapy. Within the most recent clinical note dated 01/29/2014, the injured worker presented with chronic bilateral upper extremity and neck pain. She reported that she had continued to work full time and was able to tolerate it. The injured worker also had complaints of tremors in her left hand and stated that when she picked up items her hand shakes. On physical examination, the physician reported the bilateral upper extremities were non-tender to palpation, range of motion was full at the bilateral wrist, Tinel's was mildly positive at the left wrist and was negative at the elbows. The sensation was decreased to light touch along the right forearm compared to the left upper extremity and the motor strength was 5/5 bilaterally. Her medications included Lidoderm patch, ThermaCare Heat Wrap, Voltaren 1% gel, Lyrica. The current requests are for Voltaren 1% gel: 7, Lidoderm 5% patch quantity 420, ThermaCare Heat Wrap quantity 240, and Lyrica 25 mg quantity 240. The rationale was not provided for the request. The Request for Authorization for the Voltaren 15 gel and the Lidoderm patch was provided on 02/07/2014. The Request for Authorization for the ThermaCare Heat Wrap and the Lyrica was not provided in the medical records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**VOLTAREN 1% GEL #7:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** The current request for Voltaren 1% gel #7, is not medically necessary. The California MTUS Chronic Pain Guidelines indicate that Voltaren gel 1% (diclofenac) is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). The clinical documentation provided indicated the injured worker continued to have chronic pain in her upper extremities, but there was no documentation of osteoarthritis to support the request. The current request also failed to provide the body part the medication was to be applied and the frequency. The efficacy of the medication was not provided to support continuation. As such, the request for Voltaren 1% gel #7 is not medically necessary.

**LIDODERM 5% PATCH #420:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56.

**Decision rationale:** The request for Lidoderm 5% patch #420 is not medically necessary. The California MTUS Guidelines state topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy including tricyclics or SNR antidepressants or an AED such as gabapentin or Lyrica. This is not a first line treatment and is only FDA approved for postherpetic neuralgia. The clinical documentation provided indicated the injured worker had chronic pain in her upper extremities; however, the documentation did not indicate the pain was of neuropathic origin and had failed a trial of first line therapy as she had been prescribed Lyrica. The request also failed to provide the frequency of application and area of the body part that they were to be applied. The clinical information also failed to provide the efficacy of the medication to support continuation. As such, the request for Lidoderm 5% patch #420 is not medically necessary.

**THERMACARE HEAT WRAP #240:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265-266.

**Decision rationale:** The current request for a ThermaCare Heat Wrap #240 is not medically necessary. The California MTUS/ACOEM Guidelines state that application of heat or cold

packs may be used before or after exercises and are as effective as those performed by a therapist. The ThermaCare Heat Wrap is a topical patch that is applied to the involved area; it provides sustained low level heat. The injured worker had complaints of chronic pain in her upper extremities; however, the clinical information provided failed to provide the efficacy of the treatment to support continuation and failed to indicate that local applications of heat did not provide benefit. The current request failed to provide the frequency and the area the wrap was to be applied. As such, the request for ThermaCare Heat Wrap #240 is not medically necessary.

**LYRICA 25MG #240:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 19.

**Decision rationale:** The request for Lyrica 25 mg #240 is not medically necessary. The California MTUS Guidelines indicate Lyrica is an anti-epilepsy drug are recommended for use of neuropathic pain. The clinical documentation provided did not provide the efficacy of the medication to support continued use. The request also failed to provide the frequency the medication was to be administered. As such, the request for Lyrica 25 mg #240 is not medically necessary.