

<b>Case Number:</b>	CM14-0118111		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	09/05/2000
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	07/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2014

### 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. 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, Arizona  
 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 66-year-old female who reported injury on 09/05/2000. The mechanism of injury was not provided. The medications that were requested were noted to be utilized as early as 03/31/2014. The injured worker underwent urine drug screens. The documentation of 07/03/2014 revealed the injured worker was experiencing stiffness, tenderness and weakness. The injured worker indicated the condition was in the bilateral hands. Prior therapies included massage therapy and medications. The objective evaluation revealed the injured worker had mid position station examination and gait without abnormalities. Inspection and palpation of the bones, joints and muscles were unremarkable. The testing of the cranial nerves revealed no deficits. The diagnoses included bilateral hand pain, cervicgia, bilateral elbow pain, shoulder pain bilaterally, fibromyalgia and status post hip replacement on 05/09/2012. The treatment plan included a 1 month followup for further evaluation. The subsequent documentation of 08/01/2014 revealed the injured worker had findings of de Quervain's tenosynovitis and carpal metacarpal syndrome bilaterally and some degenerative changes in the bilateral wrists. The injured worker had severe findings for intra-articular pathology, which was noted to have significantly increased from prior evaluation. There was no injection; however, there was a significant amount of swelling and pain to light touch and moderately to deep palpation. The injured worker was noted to undergo x-rays, which revealed advanced degenerative changes at the bilateral bases of the thumbs and diffuse degenerative changes. The treatment plan included medications. There was no Request for Authorization submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Nortriptyline 75mg # 30 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend antidepressants as a first line medication for the treatment of neuropathic pain, and they recommend it especially if pain is accompanied by insomnia, anxiety or depression. There should be documentation of an objective decrease in pain and objective functional improvement, to include an assessment and the changes in the use of other analgesic medications, sleep quality and duration, and psychological assessments. The clinical documentation submitted for review failed to indicate the injured worker had an objective decrease in pain and objective improvement in function. There was a lack of documentation indicating a necessity for 3 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for nortriptyline 75mg # 30 with 3 refills is not medically necessary.

**Gabapentin 300mg #270 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) or Anti-convulsants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that antiepilepsy medications are a first line medication for the treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30% to 50% and objective functional improvement. The clinical documentation submitted for review failed to indicate there was an objective decrease in pain of at least 30% to 50% and there was objective functional improvement. The request as submitted failed to indicate the frequency for the medication. Additionally, the documentation failed to indicate a necessity for 3 refills without re-evaluation. Given the above, the request for gabapentin 300mg #270 with 3 refills is not medically necessary.

**Lidoderm patch 5% #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain Chapter: Topical Analgesics

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56-57.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica). This is not a first line treatment and is only FDA approved for postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide documentation that the injured worker had a trial and failure of gabapentin or another first line therapy. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Lidoderm patch 5% #30 is not medically necessary.

**Voltaren 1% gel 100gm with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines Pain chapter: Topical Analgesics

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren 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 indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency and the body part to be treated with the medication. There was a lack of documentation indicating a necessity for 3 refills without re-evaluation. Given the above, the request for Voltaren 1% gel 100gm with 3 refills is not medically necessary.

**Nuvigil 150mg #30 with 3 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain chapter: Armodafinil (Tembe, 2011)

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

**Decision rationale:** The Official Disability Guidelines indicate that Nuvigil is not recommended solely to counteract sedation effects of narcotics. The clinical documentation submitted for review failed to indicate the rationale for the requested medication. The duration of use was since at least 03/2014. There was a lack of documentation indicating a necessity for 3 refills without re-evaluation and documentation of exceptional factors to warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the frequency for the requested medication. Given the above and the lack of documentation, the request for Nuvigil 150mg #30 with 3 refills is not medically necessary.