

Case Number:	CM14-0207840		
Date Assigned:	12/19/2014	Date of Injury:	03/02/2009
Decision Date:	02/13/2015	UR Denial Date:	11/14/2014
Priority:	Standard	Application Received:	12/11/2014

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 Rehab 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 patient is a 52 year old female with date of injury 03/02/09. The treating physician report dated 7/16/14 (32) indicates that the patient presents with pain affecting her neck. The physical examination findings reveal cervical spine ROM is 50% or normal and the Lumbar Spine ROM is 50% of expected with guarding. UE stretch reflexes (Brach, Tricep) are (2+) bilaterally. Sensory deficit and give-way weakness of the upper extremities. No motor or sensory deficits of the lower extremities. The current diagnoses are: 1. Cervical Disc disease/Cervical Radicular Symptoms 2. Possible Left Shoulder Impingement 3. Chronic low and mid-back pain likely lumbar disc disease. The utilization review report dated 11/14/14 denied the request for Voltaren, Lidoderm Patches, Gabapentin, and Home cervical traction unit based on lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request Voltaren gel with a dos of 7/16/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The patient presents with neck pain. The current request is for Retrospective request Voltaren gel with a dos of 7/16/2014. The treating physician progress report does not specify what the current request is intended for. The MTUS Guidelines are specific that topical NSIADS are for, "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." MTUS does not support the usage of Voltaren cream for treatment of the spine or radicular pain as this patient has been diagnosed with. Therefore, the request is not medically necessary.

Retrospective request for Lidoderm patches with a dos of 7/16/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm, Topical Analgesics Page(s): 56-57; 111-113.

Decision rationale: The patient presents with neck pain. The current request is for Retrospective request for Lidoderm patches with a dos of 7/16/2014. The treating physician progress report does not specify what the current request is intended for. MTUS guidelines page 57 states, "topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." The MTUS guidelines state that Lidoderm patches may be recommended for neuropathic pain when trials of antidepressants and anti-convulsants have failed. MTUS also states on page 60 that, "A record of pain and function with the medication should be recorded." The treater in this case has no documentation of the effects of this medication as recommended on page 60 of MTUS and there is no documentation of localized peripheral neuropathic pain. Therefore, the request is not medically necessary.

Retrospective request for Gabapentin 300 mg with a dos of 7/16/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49.

Decision rationale: The patient presents with neck pain. The current request is for Retrospective request for Gabapentin 300 mg with a dos of 7/16/2014. The treating physician progress report does not specify what the current request is intended for. The MTUS guidelines state, "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." In this case, there is no documentation of pain and function as required on page 60 of MTUS for medication usage for chronic pain. There is no way to tell if this medication is doing anything for this patient and the current request is not medically necessary.

Home cervical traction unit of unspecified duration: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Online Neck and Upper Back Chapter, Traction Section.

Decision rationale: The patient presents with neck pain. The current request is for Home cervical traction unit of unspecified duration. The treating physician states the current request is, "to alleviate insomnia." While ACOEM guidelines do not show strong support of traction, ODG guidelines have a more thorough discussion regarding chronic neck radiculopathy and traction. ODG recommends "home cervical patient controlled traction(using a seated over-the-door device or a supine device), for patients with radicular symptoms, in conjunction with a home exercise program. ODG does not recommend institutionally based powered traction devices. In this case, the request is for home traction unit. There is no indication of a trial of traction being completed. ODG guidelines support a home unit as long as it is not a powered device. In this case, there is no description of the exact type of traction unit being requested so there is no way to know if this is a powered device or not. Therefore, the request is not medically necessary.