

<b>Case Number:</b>	CM15-0108323		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	07/22/2014
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 51 year old male patient who sustained an industrial injury on 07/22/2014. The accident was described as while working duty as a driver he stepped out of truck his foot got stuck and resulted in him falling with injury. A podiatry visit dated 09/05/2014 reported chief complaint of left ankle pain. Medications to date include: oral anti-inflammatory agent, along with immobilization and physical therapy sessions. Objective findings showed the patient is unable to dorsiflexion, plantar flex, inversion and eversion against resistance. The assessment found the patient with left ankle sprain with what appears to be chronic regional pain syndrome. A magnetic resonance imaging scan of the left ankle is required along with consultation and medications Voltaren and Norco. The patient is to remain off from work. A primary treating office visit dated 01/22/2015 reported subjective complaint of with continued intermittent moderate low back pain and intermittent moderate left ankle pain. Objective findings showed lumbosacral tenderness to palpation about the paralumbar musculature with tenderness at the midline thoraco-lumbar junction and over the level of L5-S1 facets right greater sciatic notch. There are muscle spasms; positive straight leg raise bilaterally at 20 degrees in supine position and a positive Kemp's bilaterally. Current diagnoses are: lumbar spine strain/sprain; left ankle sprain/strain with MRI evidence of sub-acute malleolar fracture and tibiotalar effusion; fracture of left ankle by history, and rule out chronic regional pain syndrome. He may continue working modified restricted work duty.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 1%, Qty 3: Upheld**

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

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

**Decision rationale:** According to the California MTUS Guidelines, Voltaren Gel 1% (Diclofenac) is indicated for the relief of osteoarthritis in joints that lend 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. The submitted documentation does not indicate that the injured worker had a diagnosis of osteoarthritis. There is also no documentation of intolerance to other previous oral medications. In addition, there was no dosage specified for the requested medication. Medical necessity for the requested topical gel has not been established. The requested Voltaren Gel 1% is not medically necessary.

**Tramadol 50 mg Qty 60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 93-96.

**Decision rationale:** According to the California MTUS, Tramadol (Ultram) is a synthetic opioid, which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness or functional improvement, and no clear documentation that the patient has responded to ongoing opioid therapy. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

**Benadryl 50 mg Qty 30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Stress - Insomnia treatment.

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

**Decision rationale:** Diphenhydramine (Benadryl) is an antihistamine that is used for the temporary relief of seasonal and perennial allergy symptoms. The medication is sedating and has been used for short-term treatment of insomnia. In this case, the medication is being prescribed for the treatment of insomnia yet the patient reports continued insomnia, and is only able to sleep for four hours. Medical necessity for the requested oral suspension medication has not been established. The requested medication is not medically necessary.

**Topamax 50 mg Qty 60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 17-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

**Decision rationale:** Topiramate (Topamax) is an anticonvulsant (antiepilepsy) drug (AED). According to the CA MTUS and the ODG, AED's are recommended for neuropathic pain. There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy. The choice of specific agents depends on the balance between effectiveness and adverse reactions. The guidelines cite the role of AEDs in the management of non-acute pain and chronic conditions such as, polyneuropathy, post-herpetic neuralgia, central pain, spinal cord injury, postoperative pain, migraine headaches, and chronic non-specific axial low back. 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. In this case, there is no documentation of evidence of improvement with its previous use. Medical necessity for Topiramate has not been established. The requested medication is not medically necessary.

**Norco 10/325 mg Qty 90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97.

**Decision rationale:** According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's functional benefit. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.