

Case Number:	CM15-0047893		
Date Assigned:	03/19/2015	Date of Injury:	05/20/2014
Decision Date:	05/01/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/13/2015

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: California
 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:

This 57-year-old female sustained an industrial injury to the left thumb on 5/20/14. In a PR-2 dated 2/17/15, the injured worker complained of persistent left thumb pain 4/10 on the visual analog scale. The injured worker reported having difficulty with grasping and pinching activities. The injured worker requested medication refills but wanted to eventually taper medications. Physical exam was remarkable for partially amputated left thumb distal phalanx with dysesthesia noted to light touch and tenderness to palpation at the tip of the left residual thumb. The injured worker was noted to be grossly protective of the left upper extremity. Current diagnoses included neuropathic pain left thumb, partial amputation of distal phalanx left thumb and status post distal phalanx fracture. The treatment plan included medications (Gabapentin, Norco and Voltaren Gel).

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg #60 Refill: 3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 76-78, 88-89.

Decision rationale: The patient presents with persistent left thumb pain rated 4/10. The request is for Norco 5/325 MG #60 Refill: 3. The RFA provided is dated 02/20/15. Patient's diagnosis included neuropathic pain left thumb, partial amputation of distal phalanx left thumb, and status post distal phalanx fracture. The patient is to return to modified duty. For chronic opiate use in general, MTUS Guidelines page 88 and 89 states, "patient should be assessed at each visit and functioning should be measured at 6-month intervals using the numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior) as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The patient requested medication refills but reportedly wanted to eventually taper medications. The prescription for Norco was first mentioned in the progress report dated 01/13/15 and the patient has been taking it since at least then. In this case, the provider has not stated how Norco reduces pain and significantly improves patient's activities of daily living. There are no pain scales or validated instruments that address analgesia. There are no discussions in relation to the UDS's, opioid pain agreement, or CURES reports. The 4A's are not specifically addressed including discussions regarding adverse reactions, aberrant drug behavior, ADL's, etc. MTUS requires appropriate discussion of the 4A's. Given the lack of documentation as required by guidelines, the request is not medically necessary.

Voltaren Gel 1% Refill: 3: 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 persistent left thumb pain rated 4/10. The request is for Voltaren Gel 1% Refill: 3. The RFA provided is dated 02/20/15. Patient's diagnosis included neuropathic pain left thumb, partial amputation of distal phalanx left thumb, and status post distal phalanx fracture. The patient is to return to modified duty. MTUS Chronic Pain Medical Treatment Guidelines pages 111 states the following regarding topical analgesics: "Largely experimental and used with few randomized controlled trials to determine efficacy or safety." There is little to no research to support the use of many of these agents." Regarding topical NSAIDs, page 111-113 states, "indications: Osteoarthritis and tendonitis, in particular that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Voltaren gel is being prescribed for superficial pain and inflammation. Review of reports does not show prior use of this medication. The patient suffers from chronic left thumb pain and has been diagnosed with neuropathic pain, left thumb. This medication is not recommended for Neuropathic pain as there is no evidence to support use. The

patient does not presents with osteoarthritis or tendonitis for which Voltaren Gel is indicated. Furthermore, the request for 3 refills exceeds the allowed short term use (4-12 weeks). Therefore, the requested Voltaren gel is not medically necessary.