

<b>Case Number:</b>	CM15-0089847		
<b>Date Assigned:</b>	05/14/2015	<b>Date of Injury:</b>	08/06/1995
<b>Decision Date:</b>	06/18/2015	<b>UR Denial Date:</b>	05/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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 Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 58 year old male, who sustained an industrial injury on [REDACTED]. He reported a fall off a ladder approximately 15-20 feet onto the left foot. Diagnoses include primary localized osteoarthritis of the left ankle/foot, status post ankle fusion and revision, and unspecified neuralgia neuritis and radiculitis. Treatments to date include activity modification, physical therapy, and medication management. Currently, he complained of left foot pain rated 7/10 VAS. On 4/23/15, the physical examination documented healed scars to the heel region with tenderness to palpation and associated numbness. The provider documented that with orthotic shoes and medications the injured worker is able to work full time. Previous attempts to wean down medication were documented as not being successful. The plan of care included Neurontin 300 mg tablets, #90; Norco 10/325mg, #150; Prilosec 20mg, #30; and Voltaren 1% topical gel, #1 tube with one refill. This request is for Voltaren 1% topical gel and Neurontin 300mg tablets.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Neurontin 300 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

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

**Decision rationale:** According to MTUS, Neurontin has been shown to be effective for the treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered to be first line treatment for neuropathic pain. Continuous use of Neurontin cannot be certified without documentation of efficacy. Therefore the request for Neurontin 300mg #90 is not medically necessary.

**Voltaren 1% topical gel #1 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-Selective NSAIDS Page(s): 111, 107.

**Decision rationale:** Voltaren Gel (Diclofenac) is a nonsteroidal anti-inflammatory drug (NSAID). According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Diclofenac is used for osteoarthritis. There is no evidence of left lower extremity osteoarthritis. Therefore request for Voltaren 1% topical gel #1 with 1 refill is not medically necessary.