

Case Number:	CM15-0166255		
Date Assigned:	09/29/2015	Date of Injury:	08/18/2004
Decision Date:	11/12/2015	UR Denial Date:	08/10/2015
Priority:	Standard	Application Received:	08/24/2015

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, North Carolina
 Certification(s)/Specialty: Family Practice

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 52 year old male, who sustained an industrial injury on 8-18-04. The injured worker was diagnosed as having lateral epicondylitis, ulnar neuropathy, chronic pain and depression. The physical exam (1-21-15 through 6-3-15) revealed tenderness to palpation over the right lateral epicondyle and 5 out of 10 pain. Treatment to date has included right elbow surgery in 2006 and 2008, a home exercise program and psychiatric treatments. Current medications include Fluoxetine, Tramadol, Naproxen, Omeprazole, LidoPro cream, Topiramate and Voltaren gel. As of the PR2 dated 7-9-15, the injured worker reports right elbow pain. There is no documentation of the injured worker's current or previous work status. Objective findings include tenderness to palpation over the medial and lateral epicondyles, a positive Tinel's sign and pronation 0-120 degrees and supination 70 degrees. The treating physician requested Topiramate 50mg #60 x 1 refill and Voltaren gel 1% #3 tube x 2 refills. On 7-8-15 the treating physician requested a Utilization Review for Topiramate 50mg #60 x 1 refill, Voltaren gel 1% #3 tube x 2 refills, Naproxen 500mg #60, Prozac 20mg #60 x 1 refill and Tramadol 50mg #15 x 1 refill. The Utilization Review dated 8-10-15, modified the request for Topiramate 50mg #60 x 1 refill and Voltaren gel 1% #3 tube x 2 refills to Topiramate 50mg #60 and Voltaren gel 1% #3 tube and certified the request for Naproxen 500mg #60 and Prozac 20mg #60 x 1 refill. The request for Tramadol 50mg #15 x 1 refill was conditionally non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topiramate 50mg #60 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: CA MTUS Guidelines support the use of anticonvulsants such as Topamax in the treatment of neuropathic pain. Topamax has variable efficacy in treating patients with neuropathic pain. It is considered for use when other first-line anticonvulsants have failed. In this case, there is no quantifiable objective documentation of pain relief or functional improvement. The request is for a 1 month supply with refill. A refill cannot be considered until efficacy is established for the original prescription. Therefore the request is not medically necessary or appropriate.

Voltaren gel 1% #3 tubes with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: CA MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled studies to determine safety and efficacy. Voltaren gel is an NSAID indicated for short-term relief (4-12 weeks) for osteoarthritis in joints that lend themselves to topical treatment, such as ankles, elbows, foot, hand knee and wrist. Voltaren gel has not been evaluated for spine, hips and shoulder. Guidelines do not recommend Voltaren gel for neuropathic pain as there is no evidence to support its use. This patient does have ulnar neuropathy and there is no specific diagnosis of osteoarthritis. In this case, there is no objective quantifiable documentation of pain relief or functional improvement. The request is for a prescription with refill, however a refill cannot be considered until efficacy is demonstrated, therefore is not medically necessary.