

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0062818 | | |
| Date Assigned: | 04/09/2015 | Date of Injury: | 08/20/2010 |
| Decision Date: | 05/13/2015 | UR Denial Date: | 03/20/2015 |
| Priority: | Standard | Application Received: | 04/03/2015 |

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:

The injured worker is a 43 year old female, who sustained an industrial injury on 8/20/10. She reported heel pain. The injured worker was diagnosed as having right posttraumatic thoracic outlet syndrome and plantar fasciitis bilaterally with compression of posterior tibial and plantar nerves on left side. Treatment to date has included oral medications, orthotics, physical therapy, cortisone injections, fascial release surgery and impaction surgery. Currently, the injured worker complains of severe pain in right supraclavicular area that radiates into shoulder blade and down to right hand associated with worsening weakness and numbness sensation of right hand and burning pain in plantar aspect of bilateral feet. Physical exam noted sensory loss in right hand and severe tenderness in left supraclavicular area. The treatment plan included Voltaren gel, Lidoderm, Percocet patches and Neurontin.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) voltaren gel 1% #5: Upheld

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

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

Decision rationale: The patient presents with pain in the supraclavicular area that radiates into the right shoulder blade down to the right hand in the ulnar distribution and pain in the plantar aspect of both feet. The request is for ONE (1) VOLTAREN GEL 1% # 5. Physical examination to the right hand on 02/19/15 revealed decreased sensation to light touch, especially in fourth and fifth fingers. Tinel, Adson and Roos tests were positive on the right. Patient's treatments have included medications and physical therapy. Per 04/07/15 progress report, patient's diagnosis include right post-traumatic thoracic outlet syndrome, and plantar fasciitis bilaterally with compression of the posterior tibial and the plantar nerves on the left side. Patient's medications, per 02/19/15 progress report include Voltaren Gel, Lidoderm Patches, Percocet Patches, and Neurontin. Patient is permanent and stationary. The MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Recommended as an option as indicated below. Non-steroidal antiinflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." Patient has received prescriptions for Voltaren Gel from 01/14/14 and 02/19/15. However, the patient does not present with peripheral joint arthritis/tendinitis, for which an NSAID topical would be indicated. Furthermore, the treater has not discussed how this medication decreases pain and significantly improves patient's activities of daily living. MTUS page 60 require recording of pain and function when medications are used for chronic pain. Additionally, this NSAID topical cream has diminishing effects lasting less than 4 weeks, and the request for quantity 5 would be excessive, even if patient presented with appropriate indications. This request does not meet MTUS indications, therefore it IS NOT medically necessary.

One (1) Lidoderm patches 5% #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical lidocaine Page(s): 56-57, 112. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Lidoderm.

Decision rationale: The patient presents with pain in the supraclavicular area that radiates into the right shoulder blade down to the right hand in the ulnar distribution and pain in the plantar aspect of both feet. The request is for ONE (1) LIDODERM PATCHES 5% # 90. Physical examination to the right hand on 02/19/15 revealed decreased sensation to light touch, especially in fourth and fifth fingers. Tinel, Adson and Roos tests were positive on the right. Patient's treatments have included medications and physical therapy. Per 04/07/15 progress report, patient's diagnosis include right post-traumatic thoracic outlet syndrome, and plantar fasciitis bilaterally with compression of the posterior tibial and the plantar nerves on the left side. Patient's medications, per 02/19/15 progress report include Voltaren Gel, Lidoderm Patches,

Percocet Patches, and Neurontin. Patient is permanent and stationary. 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)." MTUS Page 112 also states, "Lidocaine Indication: Neuropathic pain. Recommended for localized peripheral pain." When reading ODG guidelines, it specifies that lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. The treater has discussed this request. In review of the medical records provided, the patient received prescriptions for Lidoderm 5% Patches from 01/14/14 and 02/19/15. In this case, treater does not discuss how it is used, how often and with what efficacy in terms of pain reduction and functional improvement. MTUS page 60 require recording of pain and function when medications are used for chronic pain. The request is not in accordance with guideline indications. Therefore, it IS NOT medically necessary.

One (1) Neurontin 100mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Medications for chronic pain Page(s): 18-19, 60.

Decision rationale: The patient presents with pain in the supraclavicular area that radiates into the right shoulder blade down to the right hand in the ulnar distribution and pain in the pantar aspect of both feet. The request is for ONE (1) NEURONTIN 100 MG # 90. Physical examination to the right hand on 02/19/15 revealed decreased sensation to light touch, especially in fourth and fifth fingers. Tinel, Adson and Roos tests were positive on the right. Patient's treatments have included medications and physical therapy. Per 04/07/15 progress report, patient's diagnosis include right post-traumatic thoracic outlet syndrome, and plantar fasciitis bilaterally with compression of the posterior tibial and the plantar nerves on the left side. Patient's medications, per 02/19/15 progress report include Voltaren Gel, Lidoderm Patches, Percocet Patches, and Neurontin. Patient is permanent and stationary. MTUS has the following regarding Gabapentin on pg 18, 19: "Gabapentin (Neurontin, Gabarone, generic available) 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." MTUS p60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Treater has not discussed reason for the request. UR letter dated 03/20/15 has modified the requested # 90 to # 12 tablets. In review of the medical records provided, Neurontin was prescribed in progress reports 01/08/14 and 02/19/15. However, the treater has not discussed how this medication significantly reduces patient's pain and helps with activities of daily living. MTUS page 60 states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. The request does not meet all the criteria listed by MTUS, therefore, it IS NOT medically necessary.