

Case Number:	CM15-0074790		
Date Assigned:	04/24/2015	Date of Injury:	10/24/2014
Decision Date:	07/02/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	04/20/2015

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: Internal 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 25-year-old female who sustained an industrial injury on 10/24/2014. Current diagnoses include right ulnar neuritis and right neurogenic thoracic outlet syndrome. Previous treatments included medication management, Heelbo, and physical therapy. Previous diagnostic studies include x-rays. Initial complaints included immediate tingling in the right fourth and fifth digits referring to the armpit after striking her elbow on a bolt. Report dated 03/30/2015 noted that the injured worker presented with complaints that included right elbow pain referring to the right medial hand and right axilla and cervicobrachial junction. Pain level was not included. Physical examination was positive for abnormal findings. The treatment plan included prescribing medications, consideration for an EMG/NCS and nerve block, request for a trial of occupational therapy, and continues on modified duty. Disputed treatments include Neurontin, Ultram, Voltaren gel, Lidocaine gel, and Thermacare patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 100 mg, ninety count with four refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
 Page(s): 16 - 17.

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: AEDs.

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. The records documented that the patient has neuropathic pain involving her right arm but there has been no documentation of any response to the initial trial of Neurontin therapy. There is no specific indication for the requested refills. The need for 4 refills has not been established. The requested medication is not medically necessary.

Ultram 50 mg, sixty count with four refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82.

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.

Voltaren gel 1%, six refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

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

Decision rationale: The request for Voltaren gel (one tube) to be applied to the right knee three times a day for pain and inflammation is not medically necessary. The California MTUS Guidelines state Voltaren gel 1% (diclofenac) has an FDA appropriation indicated for the relief of osteoarthritis pain 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 maximum dose should not exceed 32 g per day. The submitted documentation does not indicate that the injured worker had a diagnosis of osteoarthritis. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.

Lidocaine 3%, six refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, there is no documentation of intolerance to other previous oral medications. Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) is FDA approved for neuropathic pain, and used off-label for diabetic neuropathy. No other Lidocaine topical creams or lotions are indicated for neuropathic or non-neuropathic pain. Medical necessity for the topical analgesic has not been established. The request for retrospective treatment with this topical analgesic, containing Lidocaine, is not medically necessary.

Thermacare patches, sixty count with six refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

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

Decision rationale: ODG states that heat therapy has been found to be helpful for pain reduction and return to normal function. The claimant has right elbow and forearm pain. There is no indication that the use of Thermacare patches has prolonged pain relief and resulted in any increased function. There is no specific indication for the requested 6 refills. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.