

Case Number:	CM15-0078211		
Date Assigned:	04/29/2015	Date of Injury:	10/06/2006
Decision Date:	06/01/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	04/23/2015

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 55 year old male, who sustained an industrial injury on 10/06/2006. He reported a slip and fall onto the left side including the left knee, hip, elbow, shoulder and neck. Diagnoses include bilateral lateral epicondylitis; status post left carpal tunnel release, myofascitis, and bilateral neuritis of the wrist and forearm. He is status post left shoulder surgery in 2007 and 2009. The medical records indicated a history of intolerance to ant-inflammatory medication due to gastric and intestinal issues and due to chronic anticoagulation therapy due to a history of a deep vein thrombosis (DVT). Treatments to date include rest, ice therapy, muscle relaxers, topical analgesics and knee brace. Currently, he complained of bilateral wrist, elbow, and left knee pain. On 4/8/15, the physical examination documented tenderness of the left knee and right medial epicondyle and bilateral lateral epicondyle areas. There was decreased sensation over the C7 dermatome. The plan of care included a request for a cervical pillow and topical medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical pillow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Cervical and Thoracic Spine Disorders- Clinical Measures; Allied Health Interventions; Neck Pillow (electronically sited).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper Back, Pillow.

Decision rationale: This patient presents with neck, bilateral wrist/elbow, and left knee pain. The Request for Authorization is dated 04/08/15. The current request is for a CERVICAL PILLOW. Treatments to date include rest, ice therapy, muscle relaxers, topical analgesics, medications, surgery, physical therapy, knee injections and brace. The patient is permanent and Stationary. ODG-TWC guidelines, Neck and Upper Back section for Pillow states: Recommend use of a neck support pillow while sleeping, in conjunction with daily exercise. This RCT concluded that subjects with chronic neck pain should be treated by health professionals trained to teach both exercises and the appropriate use of a neck support pillow during sleep; either strategy alone did not give the desired clinical benefit. (Helewa, 2007) On 04/08/15, the patient reported worsening of neck pain during the night and the treating physician recommended a cervical pillow. The ODG guidelines are clear that the neck support pillow is recommended in conjunction with daily exercise. The guidelines state that the cervical pillow alone does not provide clinical benefit. The available reports do not discuss whether the patient does daily exercise, and if so, what the exercises are comprised of. The ODG criteria for use of a cervical pillow has not been met. The request for a Cervical Pillow IS NOT medically necessary.

Voltaren 1% gel: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: This patient presents with neck, bilateral wrist/elbow, and left knee pain. The Request for Authorization is dated 04/08/15. The current request is for VOLTAREN 1% GEL. Treatments to date include rest, ice therapy, muscle relaxers, topical analgesics, medications, surgery, physical therapy and brace. The patient is Permanent and Stationary. For topical agents, the MTUS Guidelines page 111 states, "Topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." MTUS further states "Neuropathic pain: Not recommended as there is no evidence to support. FDA approved agent: Voltaren gel 1% (Diclofenac): Indicated for relief of osteoarthritis pain and joints that lend themselves to topical treatment ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for the treatment of the spine, hip, or shoulder." The patient's current medications include Voltaren gel, Lidoderm patches and Tramadol. The patient has been utilizing this medication since at least 01/07/15. The patient meets the indication for the use of a topical NSAID due to his chronic knee, wrist and elbow pain; however, further use cannot be supported as there is no documentation of pain relief or functional improvement with using this topical agent. The MTUS guidelines page 60 states, "A record of pain and function with the

medication should be recorded" when medications are used for chronic pain. Given the lack of discussion regarding medication efficacy, recommendation for further use cannot be made. This request IS NOT medically necessary.

Lidoderm 5% patches quantity 30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: This patient presents with neck, bilateral wrist/elbow, and left knee pain. The Request for Authorization is dated 04/08/15. The current request is for LIDODERM 5% PATCHES QUANTITY 30. Treatments to date include rest, ice therapy, muscle relaxers, topical analgesics, medications, surgery, physical therapy and brace. The patient is Permanent and Stationary. The 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, Pain Chapter on Lidoderm, 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 patient's current medications include Voltaren gel, Lidoderm patches and Tramadol. The patient has been utilizing this medication since at least 01/07/15. In this case, there is no documentation of how the Lidoderm patch 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. Given the lack of discussion regarding medication efficacy, recommendation for further use cannot be made. This request IS NOT medically necessary.