

Case Number:	CM13-0016582		
Date Assigned:	11/06/2013	Date of Injury:	01/08/2010
Decision Date:	10/29/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/26/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 41 year old male with a work injury dated 1/8/12. The diagnoses include acquired spondylolisthesis; closed fracture of the sacrum and coccyx; degeneration of the cervical intervertebral disc; lumbar intervertebral disc without myelopathy; lumbar radiculopathy; cervical radiculopathy. Under consideration is a request for 1 prescription of Norco 10/325mg #60; Dendracin Cream #120 ml; Ambien 10mg #30; Zanaflex 4MG #60. There is a primary treating physician report dated 6/24/13 that states that the patient continues to complain of severe pain affecting the right upper extremity. This is associated with numbness and tingling. The patient continues to be symptomatic in regards to neck and low back pain. The pain appears to affect all extremities. He reports several episodes over the last month where the pain was unrelenting and radiated down the right upper extremity with numbness and tingling. He continues to experience headaches particularly over the posterior portion. He experiences pain and numbness affecting the lower extremities, right greater than left. He continues to have residual pain at the site of the ilioinguinal hernia repair. He continues to see a psychologist for ongoing depression and insomnia. The patient's current medications include Neurontin 600 mg three times per day for neuropathic pain, Norco 10/325 mg twice a day for breakthrough pain, Zanaflex 4 mg twice a day for muscle spasm, and Ambien 10 mg q.h.s. for insomnia. He denies any side effects from his medications. The patient also continues to use the Dendracin Lotion for neuropathic pain. On a visual analog scale, the patient rates his pain at a 5-6/10 with medication and without medication, pain escalates to a 10/10. He reports several episodes over the last month where his pain was at a 9-10/10 and medication do not appear to be helpful. However, his current regimen appears to be beneficial to control his baseline chronic pain. He states for the most part, the pain is well managed and controlled. He is not having any side effects. He reports some

improvement in function and decrease of pain levels when medications are taken. The treatment plan includes a refill of medications including Norco, Zanaflex, Neurontin, Ambien, Dendracin, and Toradol.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION OF NORCO 10/325MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines OPIOIDS Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

Decision rationale: 1 prescription of Norco 10/325mg #60 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The documentation indicates that the patient has been on Norco dating back to 2012. The guidelines do not support long term opioid use without evidence of improvement in function or analgesia. The documentation does not reveal significant functional improvement on long term Norco. The request for 1 prescription of Norco 10/325mg #60 is not medically necessary.

1 PRESCRIPTION OF AMBIEN 10MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental illness and stress-Insomnia treatment and Zolpidem

Decision rationale: 1 prescription of Ambien 10mg #30 is not medically necessary per the ODG guidelines. The MTUS was reviewed but does not address insomnia treatment. The ODG states that Ambien is not recommended for long term use. The ODG recommends pharmacological agents only after careful sleep evaluation. The documentation indicates that the patient has been on this medication since 2012 and still continues have insomnia. The guidelines do not recommend this medication for long term use. The request for Ambien 10mg #30 is not medically necessary.

1 PRESCRIPTION OF DENDRACIN CREAM #120ML: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

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

Decision rationale: 1 prescription of Dendracin cream #120ML is not medically necessary per the MTUS Guidelines. Dendracin Cream contains: Active ingredients. Methyl Salicylate 30%; Capsaicin 0.0375%; Menthol USP 10%. Per MTUS guidelines, " Topical Analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. ." Additionally , the MTUS guidelines state, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended.". Salicylate topicals are recommended by the MTUS and Dendracin contains methyl salicylate . The MTUS guidelines do not specifically discuss menthol. There is mention of Ben-Gay which has menthol in it and is medically used per MTUS for chronic pain. Capsaicin topical 0.375% is not recommended. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The documentation does not indicate that the patient is intolerant to oral medications. The documentation states that Dendracin has been used since 2012 without significant functional improvement. The request for Dendracin is not medically necessary.

1 PRESCRIPTION OF ZANAFLEX 4MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN) Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) page 63; Tizanidine (Zanaflex, generic available) Page(s): 63,65.

Decision rationale: 1 prescription of Zanaflex 4mg #60 is not medically necessary per MTUS guidelines. The MTUS recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic pain. Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. The documentation submitted reveals that the patient has been on this medication since 2012 which exceeds the recommendation to use this medication as a short term option. The request for 1 prescription of Zanaflex 4mg #60 is not medically necessary.