

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM13-0023273 |                              |            |
| <b>Date Assigned:</b> | 03/19/2014   | <b>Date of Injury:</b>       | 08/23/2005 |
| <b>Decision Date:</b> | 05/29/2014   | <b>UR Denial Date:</b>       | 09/03/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/16/2013 |

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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 an employee of [REDACTED] and has submitted a claim for chronic pain syndromes associated with an industrial injury date of August 23, 2005. Treatment to date has included cervical fusion and hardware removal, home exercises, physical therapy, opioid and non-opioid pain medications which included Neurontin, Percocet, and Soma. Utilization review from September 3, 2013 denied the request for Neurontin due to failure of Neurontin previously, Soma due to failure from previous prescription and non-recommendation via guidelines, Lidoderm due to insufficient data concerning failure of first line drugs, Tizanidine due to long-term use, and Oxycodone and OxyContin due to exceeding the morphine equivalents per day. Medical records from 2013 were reviewed showing that the patient has a complicated surgical history as well as chronic pain syndrome. Medications help control the pain at a level of 5/10 from 9-10/10, which has been stable over the past year on these medications and has enabled her to maintain her level of activities of daily living. The patient complains of upper extremity numbness and tingling both at the elbow and wrist radiating down the arms and shoulders towards the elbows. There were no aberrant drug-seeking behaviors noted. Physical exam demonstrates decreased cervical range of motion with tenderness over the cervical area.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE REQUEST FOR NEURONTIN 900MG TID: 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 Page(s): 16-22.

**Decision rationale:** As stated on page 16-22 of the Chronic Pain Medical Treatment Guidelines, anti-epilepsy drugs are recommended for neuropathic pain. Outcomes with at least 50% reduction of pain are considered good responses while those with 30% reduction may consider another or additional agent. In this case, the patient complains of numbness and tingling in upper extremities but the most recent neurological exam did not demonstrate sensory deficits in a specific nerve distribution. This medication has been used for well over a year, with limited assessment of specific efficacy or Neurontin therapy. Therefore, retrospective request for Neurontin 900mg 3 times a day is not medically necessary and appropriate.

**RETROSPECTIVE REQUEST FOR SOMA 350MG 4 TIMES A DAY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29, 65.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29.

**Decision rationale:** As stated on page 29 of the Chronic Pain Medical Treatment Guidelines, Carisoprodol is not recommended as it is not indicated for long-term use as well as having an active metabolite which is a schedule IV controlled substance. In this case, there is no objective evidence of muscular spasm or stiffness. In addition, this medication produces a schedule IV metabolite and there is no discussion concerning variance from the guidelines. This medication has been used for well over a year, with no specific assessment of treatment response. The specific duration is also not indicated in the request. Therefore, the retrospective request for soma 350mg 4 times a day is not medically necessary and appropriate.

**RETROSPECTIVE REQUEST FOR LIDODERM 5% TOPICAL APPLY TO AREA OF PAIN FOR 24 HRS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57.

**Decision rationale:** As stated on page 56-57 of the Chronic Pain Medical Treatment Guidelines, Lidoderm is 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). In this case, the patient complains of numbness and tingling in upper extremities but the most recent neurological exam did not demonstrate sensory deficits in a specific nerve distribution.

This medication has been in use for at least a year, with no specific assessment of treatment response. The request also does not indicate frequency, duration, and amount requested. Therefore, the retrospective request for Lidoderm 5% topical apply to area of pain for 24 hrs is not medically necessary and appropriate.

**RETROSPECTIVE REQUEST FOR TIZANIDINE 6MG ORAL CAPSULE, 1-2 Q 6 HRS PRN MUSCLE SPASM: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

**Decision rationale:** As stated on page 66 of the California MTUS Chronic Pain Medical Treatment Guidelines, Tizanidine is FDA approved for the management of spasticity with an unlabeled use for low-back pain. In this case, the patient complains of back pain but rather neck pain. The physical exam did not demonstrate any evidence of spasticity or muscle spasms. This medication has been in use for at least a year with no specific assessment of treatment response. The request does not indicate the duration of use. Therefore, the request for retrospective request for Tizanidine 6mg oral capsule, 1-2 every 6 hrs as needed muscle spasm is not medically necessary and appropriate.

**RETROSPECTIVE REQUEST FOR OXYCODONE 30MG, 1 AT BEDTIME AND EVERY 6 HRS AS NEEDED FOR BREAKTHROUGH PAIN 9AVOID MORE THAN 4 PER DAY): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 86.

**Decision rationale:** As stated on page 86 of the Chronic Pain Medical Treatment Guidelines, the total daily dose of opioids should not exceed 120 mg oral morphine equivalents and should only be increased beyond this only after pain management consultation has been done. In this case, the patient is being seen by a pain management specialist and has reported improvements while on this medication for over a year. However, the request does not indicate an amount to be dispensed. It is unclear whether narcotics or any of the other medications were responsible for the patient's relief in pain. Therefore, the request for retrospective request for Oxycodone 30mg, 1 at bedtime and every 6 hrs as needed for breakthrough pain 9avoid more than 4 per day) is not medically necessary and appropriate.

**RETROSPECTIVE REQUEST FOR OXYCONTIN 80MG ORAL TABLET, ER, 2 TABS AT 8AM AND 1 AT 5-6 PM: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 86.

**Decision rationale:** As stated on page 86 of the Chronic Pain Medical Treatment Guidelines, the total daily dose of opioids should not exceed 120 mg oral morphine equivalents and should only be increased beyond this only after pain management consultation has been done. In this case, the patient is being seen by a pain management specialist and has reported improvements while on this medication for over a year. However, at the request does not indicate an amount to be dispensed. It is unclear whether narcotics or any of the other medications were responsible for the patient's relief in pain. Therefore, the request for retrospective request for Oxycontin 80 mg oral tablets, ER, 2 Tablets At 8am And 1 At 5-6 Pm is not medically necessary and appropriate.