

<b>Case Number:</b>	CM13-0041401		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	09/27/2007
<b>Decision Date:</b>	02/05/2014	<b>UR Denial Date:</b>	10/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Oklahoma and Texas. 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 physician 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 39-year-old female who reported an injury on 09/21/2007 that ultimately resulted in a rotator cuff repair. The patient also developed cervical complaints and an MRI revealed multiple-level degenerative disc disease. The patient underwent a radiofrequency ablation at the C3, C4, and C5 medial branch nerves. The patient's most recent clinical evaluation reported that the patient had continued cervical spine pain rated at a 5/10. The patient's medications included: Topiramate, tizanidine, Norco, methadone, Lidoderm patches, gabapentin, Cymbalta, and Biofreeze. The patient's treatment plan included discontinuation of Norco, methadone, and Cymbalta with initiation of MS Contin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm 5% patch #30:** Upheld

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

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

**Decision rationale:** The requested Lidoderm 5% patch, #30, is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence the patient

has been on this medication for an extended duration. California Medical Treatment Utilization Schedule recommends the continued use of a Lidoderm patch be supported by increased functional benefit and significant pain relief. The clinical documentation submitted for review does not provide any evidence of significant pain relief or functional benefit related to this medication. As such, the requested Lidoderm 5% patch, #30, is not medically necessary or appropriate.

**Norco 10/325mg #240:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

**Decision rationale:** The requested Norco 10/325 mg, #240, is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends continued use of opioids be based on quantitative evaluation of symptom relief, management of side effects, functional benefit, and monitoring for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient receives any functional benefit or significant pain relief as a result of this medication. Additionally, there is no documentation that the patient is regularly monitored for aberrant behavior or has a pain contract with the prescribing physician. As such, continued use of Norco 10/325 mg, #240, is not medically necessary or appropriate.

**Oxcarbazepine 150mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs), Page(s): 60 and 16.

**Decision rationale:** The requested oxcarbazepine is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. California Medical Treatment Utilization Schedule recommends that continued use of medications in the management of a patient's chronic pain be supported by a quantitative assessment of symptom response and documentation of specific functional benefit. The clinical documentation submitted for review does not provide any evidence that this medication provides any symptom relief or functional benefit for this patient. Therefore, continued use of this medication would not be indicated. As such, the requested oxcarbazepine 150 mg, #180, is not medically necessary or appropriate