

<b>Case Number:</b>	CM14-0016968		
<b>Date Assigned:</b>	03/07/2014	<b>Date of Injury:</b>	11/18/2005
<b>Decision Date:</b>	04/24/2014	<b>UR Denial Date:</b>	02/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2014

### 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 & Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Texas and Oklahoma. 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 39-year-old female who reported an injury on 11/18/2005. The mechanism of injury was not stated. The patient is currently diagnosed with displacement of cervical intervertebral disc without myelopathy, cervical post laminectomy syndrome, carpal tunnel syndrome, shoulder joint pain and psychalgia. The patient was seen by [REDACTED] 01/24/2014. The patient reported ongoing pain to the right side of the neck with radiation into the right upper extremity, rated 8/10. The patient also reported pain with burning, numbness and tingling. The patient's physical examination on that date revealed diminished sensation to light touch in the C6-7 dermatomal distribution on the right, an antalgic gait, swelling over the wrist joint of the right upper extremity, atrophy in the general musculature of the right upper extremity, soft tissue tenderness, and normal range of motion. Treatment recommendations included continuation of current medications as well as renal and hepatic labs.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**OXYCONTIN 30MG #60 QUANTITY 60.00:** 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): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has utilized OxyContin 30 mg since at least 11/2013. Despite ongoing use of this medication, the patient continues to report high levels of pain. There is no change in the patient's physical examination that would indicate functional improvement. Based on the clinical information received, the request is non-certified.

**PERCOCET 10/325MG #120 QUANTITY 120.00:** 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): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has utilized Percocet 10/325 mg since at least 10/2013. Despite ongoing use of this medication, the patient continues to report persistent pain. There is no change in the patient's physical examination that would indicate functional improvement. Based on the clinical information received, the request is non-certified.

**FLECTOR PATCHES #60 TIMES THREE REFILLS QUANTITY 240.00:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The only FDA approved topical NSAID is diclofenac, which is indicated for the relief of osteoarthritis pain. It has not been evaluated for treatment of the spine, hip or shoulder. As per the documentation submitted, the patient has utilized Flector 1.3% patch since at least 10/2013. Despite ongoing use of this medication, the patient continues to report persistent pain. As guidelines do not recommend this medication for treatment of the spine, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

**CYCLOBENZAPRINE 10MG #45 TIMES THREE REFILLS QUANTITY 180.00:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. As per the documentation submitted, the patient has utilized Cyclobenzaprine 10 mg tablets since at least 10/2013. Despite ongoing use of this medication, the patient continues to report persistent symptoms. There was no documentation of palpable muscle spasm or spasticity upon physical examination. As guidelines do not recommend long term use of this medication, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.

**KIDNEY FUNCTION TEST QUANTITY 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70.

**Decision rationale:** California MTUS Guidelines recognize the risk for liver and kidney problems due to long term and high dose use of NSAIDS and acetaminophen. There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy. Repeat testing is based on patient risk factors and related symptoms suggesting a problem. As per the documentation submitted, the patient does not exhibit any signs or symptoms suggestive of an abnormality due to medication use. The medical necessity for the requested service has not been established. As such, the request is non-certified.

**LIVER FUNCTION TEST QUANTITY 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70.

**Decision rationale:** California MTUS Guidelines recognize the risk for liver and kidney problems due to long term and high dose use of NSAIDS and acetaminophen. There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy. Repeat testing is based on patient risk factors and related symptoms suggesting a problem. As per the documentation submitted, the patient does not exhibit any signs or symptoms suggestive of an abnormality due to medication use. The medical necessity for the requested service has not been established. As such, the request is non-certified.

