

<b>Case Number:</b>	CM14-0172171		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	05/31/2006
<b>Decision Date:</b>	11/21/2014	<b>UR Denial Date:</b>	09/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/17/2014

### 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 Family Medicine and is licensed to practice in Utah. 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 claimant is a 60-year-old female. Her date of injury is 5/31/2006. The mechanism of injury was not described. The patient has been diagnosed with bilateral knee degenerative joint disease, osteoarthritis in bilateral knees, and L4-L5 annular tear. The patient's treatments have included imaging studies and medications. The physical exam findings dated 3/10/2014 showed the knee exam with palpable tenderness over the medial and lateral side. There is crepitation of the patella on the left, and the apprehension test is negative. The McMurray's test is positive on the left and negative on the right. There is non-specific pain upon meniscal testing. Clinical documents of 7/7/2014 state she has numbness in the hands bilaterally, but there are no physical exam findings for the hands. The patient's medications have included, but are not limited to, Gralise, Celebrex, Norco, Zanaflex, Hydroxyzine, Prilosec, Prochlorperazine, Topiramate, Motrin, Dulcolax, Ambien, Ascort, Proventil, Sertraline and Sonata.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 600mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 16 and 49.

**Decision rationale:** MTUS guidelines were reviewed in regards to this specific case. Clinical documents were reviewed. According to the above-cited guidelines, "Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy." To determine a good outcome, "A 'good' response to the use of AEDs has been defined as a 50% reduction in pain and a 'moderate' response as a 30% reduction... It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the 'trigger' for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails... After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use." There is no documentation that states the patient has a diagnosis of a radicular pain. According to the clinical documentation provided and current MTUS guidelines, Gabapentin is not indicated as a medical necessity to the patient at this time.

**Norco 10/325mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-96.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 75 and 79.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The MTUS indicates that ongoing management of opioids includes documentation of prescriptions given from a single practitioner, prescriptions from a single pharmacy and the lowest dose should be used to improve function. There should also be an ongoing review of "the 4 A's", including analgesia, activities of daily living, adverse side effects, and aberrant drug behaviors. According to the clinical documents, it is unclear that the medications are from a single practitioner or a single pharmacy. Documentation for activities of daily living, adverse side effects, and aberrant drug usage is unclear at this time. There is no clear functional gain that has been documented with this medication. There has been a taper of this medication that has been recommended and approved. According to the clinical documentation provided and current MTUS guidelines, Norco, as requested above, is not indicated a medical necessity to the patient at this time.

**Topiramate 100mg #30:** 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 Anti-epilepsy drugs (AEDs) - Topiramate Page(s): 21.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Topiramate. MTUS guidelines state this medication has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of central etiology. It is still considered for use in neuropathic pain when other anticonvulsants fail. There is lack of documentation that states the patient has a diagnosis of radicular pain. The clinical documents do not state that the patient has taken other anticonvulsants and failed treatment. According to the clinical documentation provided and current MTUS guidelines, Topiramate is not indicated as a medical necessity to the patient at this time.

**Zanaflex 4mg #60:** Upheld

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

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

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Zanaflex. MTUS guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP (low back pain). Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs (non-steroidal anti-inflammatory drugs) in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The clinical records lack documentation that this medication is to be used for short-term treatment. There are also no reported muscle spasms in the physical examination. This medication is not recommended for long-term usage. A modified approval of this medication for the purposes of weaning has been suggested and approved by utilization review. According to the clinical documentation provided and current MTUS guidelines, Zanaflex is not indicated as a medical necessity to the patient at this time.