

<b>Case Number:</b>	CM14-0036638		
<b>Date Assigned:</b>	03/28/2014	<b>Date of Injury:</b>	04/28/2006
<b>Decision Date:</b>	07/15/2014	<b>UR Denial Date:</b>	02/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2014

### 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 Minnesota. 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 injured worker is a 58-year-old male with a reported injury on 04/28/2006. The mechanism of injury was not provided within the clinical notes. The clinical note dated 02/10/2014 reported the injured worker complained of pain to his neck, shoulders, arms, upper back, and lower back. The physical examination revealed tenderness to palpation to the cervical spine. It was noted that the injured worker had neurological symptoms at the right C3, C4, and C5 dermatomal region indicating radiculopathy, with mild signs and symptoms to the C6 area. The injured worker's cervical spine range of motion demonstrated flexion, extension, and lateral bending with moderate restrictions. The injured worker's prescribed medication list included Zanaflex, Norco, Icy Hot, Ibuprofen, Flector, Docusate Sodium, Dendracin, Avinza (two separate doses), and Amitriptyline. The injured worker's diagnoses included long-term use of other medications, cervical radiculopathy, cervical spondylosis without myelopathy, myalgia, and myositis (unspecified), post-laminectomy syndrome of cervical region, and chronic pain due to trauma. The provider requested Zanaflex, Norco, Icy Hot, Ibuprofen, Flector, Avinza, and Dendracin. The request for authorization was submitted on 03/24/2004. The injured worker's prior treatments included heating pad, ice therapy, massage therapy, physical therapy, and aquatic therapy. The amount of sessions and dates of previous therapies were not provided within the clinical documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ZANAFLEX 6MG #90 WITH 1 REFILL: Upheld**

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

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

**Decision rationale:** The injured worker complained of neck and back pain. The provider's rationale for Zanaflex was not provided within the clinical notes. The Chronic Pain Medical Treatment Guidelines recognize Zanaflex as a centrally acting alpha-2 adrenergic agonist muscle relaxant that is FDA approved for management of spasticity; unlabeled use for low back pain. There is a lack of clinical information provided documenting the efficacy of Zanaflex as evidenced by decreased pain and significant objective functional improvements. Furthermore, the requesting provider did not specify the utilization frequency of the medication being requested. Therefore, the requested Zanaflex 6mg #90 with 1 refill is not medically necessary.

**NORCO 10/325MG #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, Opioids, criteria for use Page(s): 91; 78.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that Norco is a short-acting opioid, which is an effective method in controlling chronic, intermittent or breakthrough pain. The guidelines recognize four domains that have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. In this case, the injured worker complained of neck and back pain. The provider's rationale for Norco was not provided in the clinical notes. There is a lack of clinical information provided documenting the efficacy of Norco as evidenced by decreased pain and significant objective functional improvements. Furthermore, the requesting provider did not specify the utilization frequency of the medication being requested. Therefore, the request for Norco 10/325mg is not medically necessary.

**ICY HOT 1 GM WITH 1 REFILL:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SALICYLATE TOPICALS Page(s): 105.

**Decision rationale:** The injured worker complained of neck and back pain. The provider's rationale for Icy Hot was not provided in the clinical notes. The generic name for Icy Hot is

methyl salicylate topical. The Chronic Pain Medical Treatment Guidelines state that topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. There is a lack of clinical information provided documenting the efficacy of Icy Hot as evidenced by decreased pain and significant objective functional improvements. Furthermore, the requesting provider did not specify the utilization frequency or location of application of the medication being requested. Therefore, the requested Icy Hot 1gm is not medically necessary.

**IBUPROFEN 600MG #90 WITH 1 REFILL:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-INFLAMMATORY MEDICATIONS Page(s): 22.

**Decision rationale:** The injured worker complained of neck and back pain. The provider's rationale for Ibuprofen was not provided in the clinical notes. The Chronic Pain Medical Treatment Guidelines recognize Ibuprofen as a NSAID. Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. There is a lack of clinical information provided documenting the efficacy of ibuprofen as evidenced by decreased pain and significant objective functional improvements. Moreover, there is a lack of clinical information provided indicating how long the injured worker has use ibuprofen; the guidelines do not recommend long-term utilization. Furthermore, the requesting provider did not specify the utilization frequency of the medication being requested. Therefore, the requested Ibuprofen 600mg is not medically necessary.

**FLECTOR 1.3% #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 112.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recognize Flector patch as a non-steroidal anti-inflammatory drug. Topical application for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. There is a lack of clinical information provided indicating the efficacy of the Flector patch as evidenced by decreased pain and significant objective functional improvements. The requesting provider did not specify the application location of the medication being requested; the guidelines do not recommend the medication for treatment of the spine, hip, or shoulder. Furthermore, the requesting provider did not specify the utilization frequency of the medication being requested. Therefore, the requested Flector 1.3% is not medically necessary.

**AVINZA 75MG #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Avinza (morphine sulfate), Opioids, criteria for use Page(s): 23; 78.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state Avinza capsules are a brand of modified-release morphine sulfate indicated for once daily administration for the relief of moderate to severe breakthrough pain requiring continuous, around-the-clock opioid therapy for an extended period of time. The guidelines recognize four domains that have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. There is a lack of clinical information provided documenting the efficacy of Avinza as evidenced by decreased pain and significant objective functional improvements. The guidelines recommend Avinza capsules to be utilized once daily; the requesting provider did not specify the utilization frequency of the medication being requested. Therefore, the requested Avinza 75mg is not medically necessary.

**AVINZA 90MG #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Avinza (morphine sulfate), Opioids, criteria for use Page(s): 23;78.

**Decision rationale:** The injured worker complained of neck and back pain. The provider's rationale is not indicated in the clinical notes. The Chronic Pain Medical Treatment Guidelines state that Avinza capsules are a brand of modified-release morphine sulfate indicated for once daily administration for the relief of moderate to severe breakthrough pain requiring continuous, around-the-clock opioid therapy for an extended period of time. The guidelines recognize four domains that have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. There is a lack of clinical information provided documenting the efficacy of Avinza as evidenced by decreased pain and significant objective functional improvements. The guidelines recommend Avinza capsules to be utilized once daily; the requesting provider did not specify the utilization frequency of the medication being requested. Therefore, the requested Avinza 90mg is not medically necessary.

**DENDRACIN 0.0375% PM WITH 2 REFILLS:** 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): 111-112.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recommend capsaicin only as an option in patients who have not responded or are intolerant to other treatments. Capsaicin is generally available as a 0.025% formulation and a 0.075% formulation. 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 guidelines also state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Dendracin contains 0.037% capsaicin. The guidelines specifically state that there is no current medication that this increase over a 0.025% formulation would provide any further efficacy. Thus, the guidelines do not recommend 0.0375% capsaicin. Furthermore, the guidelines state if one component or dosage is not approved, the entire medication is not recommended. Therefore, the requested Dendracin 0.0375% is not medically necessary.