

<b>Case Number:</b>	CM14-0057126		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	10/22/1999
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	04/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2014

### 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 patient is a 51 year-old male. The patient's date of injury is 10/22/1999. The mechanism of injury is not stated in the clinical documents. The patient has been diagnosed with chronic severe neck pain, multiple level C spine fusion, headaches, myofascial pain and spasm, and hypertension. The patient's treatments have included surgery, imaging studies, physical therapy or home therapy, and medications. The physical exam findings dated Oct 1, 2013 show the patient in no acute distress. The lower neck has pain. There is significantly limited range of motion due to pain. The neck is reported a 3-4 of 5 strength with flexion and extension. There is occipital tenderness noted in the left side. There are no new neuro or motor deficits noted. Reviews of systems are noted under gastrointestinal as normal. The patient's medications have included, but are not limited to, Baclofen, Cymbalta, Dexilant, Dilaudid, Duexis, Flexeril, Fortesa, Gabapentin, Methadone, Subsys, Zanaflex, and Zomig.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gralise 600mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs).

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

**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. (Eisenberg, 2007) (Jensen, 2006) 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. According to the clinical documents; there is no specific documentation relating to pain relief with this medication, only that the medications are continued. Other documents state the patient still has 9/10 pain. Therefore, Gralise (Gabapentin) is not indicated as a medical necessity to the patient at this time.

**Zomig #10:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Head Procedure Summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head Procedure Summary.

**Decision rationale:** MTUS treatment guidelines do not specifically mention Zomig. The Official Disability Guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Zomig. Guidelines state the following: recommended for migraine headaches. The clinical documents lack documentation that state the patient suffers from Migraine headaches, as opposed to neck pain. According to the clinical documentation provided and current guidelines; Zomig, as stated above, is not indicated as a medical necessity to the patient at this time.

**Baclofen 10mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for Pain. Decision based on Non-MTUS Citation Official Disability Guidelines Muscle Relaxants for Pain.

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

**Decision rationale:** MTUS guidelines state the following: Baclofen is indicated for as an option for use in short course of therapy. Efficacy is greatest in the first 1-2 weeks of treatment with this medication. MTUS states that treatment course should be brief. According to the clinical documents, the Baclofen requested is not being used for short term therapy. Following guidelines as listed above, there is no indication for the use of Baclofen. At this time, the request is not deemed as a medical necessity.

**Fortesta #1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com, Foresta Gel.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement for hypogonadism Page(s): 110-111.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Fortesta. MTUS guidelines state the following: Testosterone is indicated for replacement therapy in males for conditions associated with a deficiency or absence of endogenous testosterone. The clinical documents lack documentation that shows low testosterone levels. According to the clinical documentation provided and current MTUS guidelines; Fortesta (Testosterone) 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 Muscle Relaxants for Pain. Decision based on Non-MTUS Citation Official Disability Guidelines: Muscle Relaxants for Pain.

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

**Decision rationale:** MTUS guidelines state the following: Tizanidine is indicated for as an option for use in short course of therapy. Efficacy is greatest in the first 1-2 weeks of treatment with this medication. MTUS states that treatment course should be brief. According to the clinical documents, the Tizanidine requested is not being used for short term therapy. Following guidelines as listed above, there is no indication for the use of Tizanidine. At this time, the request is not deemed as a medical necessity.

**Dexilant 60mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 67-69.

**Decision rationale:** According to the clinical documents, there is no documentation that the patient has a history of reflux or gastrointestinal symptoms that would warrant the usage of this medication. There is also lack of evidence that the patient is at increased risk for gastrointestinal complications that would warrant the use of this medication in the patient. The use of Dexilant, as stated in the above request, is determined not to be a medical necessity at this time.

**Methadone 10mg #90:** Upheld

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

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

**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 records, it is unclear what the results/outcome of taking that medication was. The Plan sections of the clinical documents state that the 4 A's were discussed, but not specific documentation supports the results of these. Methadone is not indicated a medical necessity to the patient at this time.

**Duexis #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain Procedure Summary States That Duexis Ibuprofen and Famotidine is not Recommended as a First-Line Drug.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 66-73.

**Decision rationale:** Guidelines state that these medications are recommended at the lowest dose for the shortest period in patient with moderate to severe pain. Documentation for activities of daily living, adverse side effects, and aberrant drug usage is unclear at this time. There is no documentation of the effectiveness of the medication noted. According to the clinical documentation provided and current MTUS guidelines; Duexis is not indicated as a medical necessity to the patient at this time.

**Flexeril 10mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for Pain. Decision based on Non-MTUS Citation Official Disability Guidelines: Muscle Relaxants for Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

**Decision rationale:** MTUS guidelines state the following: Flexeril is indicated for as an option for use in short course of therapy. Efficacy is greatest in the first four days of treatment with this medication. MTUS states that treatment course should be brief. According to the clinical documents, the Flexeril requested is not being used for short term therapy. Following guidelines as listed above, there is no indication for the use of Flexeril. At this time, the request is not deemed as a medical necessity.