

<b>Case Number:</b>	CM14-0074218		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	06/21/2003
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	04/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/21/2014

### 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 and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 61-year-old male was reportedly injured on 6/21/2003. The mechanism of injury was noted as a fall. The most recent progress note, dated 5/22/2014, indicated that there were ongoing complaints of left arm/hand pain. Physical examination demonstrated positive left upper extremity tenderness, edema, reduced range of motion (rom) and allodynia. No recent diagnostic imaging studies available for review. UDS dated 1/30/2014 detected Oxycodone. Diagnoses: Neuropathic pain in left upper extremity, chronic pain syndrome, opioid dependency and opioid-induced constipation. Previous treatment included Percocet, Lidoderm Patches, Zanaflex, Gabapentin and Carters. A request had been made for Carters 5 mg #300 with 5 refills, Lidoderm Patch 5% #30 with 5 refills, Percocet 10/325 mg #120, Zanaflex 4 mg #120 with 5 refills in the utilization review on 4/16/2014. A modified certification was granted for Carters #100, Lidoderm Patches #20, and Percocet #60 for weaning purposes; Zanaflex received a non-certification.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CARTERS 5MG #300 WITH 5 REFILLS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN Page(s): 77.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77.

**Decision rationale:** Carters active ingredient is Bisacodyl, which is a laxative used to stimulate gastric motility in the treatment of constipation. MTUS guidelines support prophylactic treatment of constipation when starting opioids. Given that Percocet is not considered medically necessary, a stool softener and/or laxative is not medically necessary.

**LIDODERM 5% PATCHES, APPLY TO ONE AFFECTED AREA 12 HOURS ON AND 12 HOURS OFF, #30 WITH 5 REFILLS:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN LIDODERM Page(s): 56.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56.

**Decision rationale:** MTUS guidelines support the use of topical lidocaine for individuals with neuropathic pain that have failed treatment with first-line therapy including antidepressants or anti-epileptic medications. Based on the clinical documentation provided, the claimant has a diagnosis of chronic neuropathic pain and currently taking gabapentin. The request is considered medically necessary.

**PERCOCET 10/325MG, 1 BY MOUTH EVERY 4 HOURS AS NEEDED FOR PAIN, #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN OPIOIDS Page(s): 75, 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74, 78, 93.

**Decision rationale:** MTUS guidelines support short-acting opiates for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic left arm pain; however, there is no clinical documentation of improvement in the pain or function with the current regimen. As such, this request is not considered medically necessary.

**ZANAFLEX 4MG EVERY 6 HOURS AS NEEDED FOR SPASM #120 WITH 5 REFILLS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain/ANTISPASMODICS Page(s): 64-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/ Antispasmodic Drugs Page(s): 66.

**Decision rationale:** Zanaflex (tizanidine) is a centrally acting alpha 2-adrenergic agonist that is FDA approved for management of spasticity. Muscle relaxants are only indicated as 2nd line options for short-term treatment. It appears that this medication is being used on a chronic basis, which is not supported by MTUS treatment guidelines. Therefore, this medication is not considered medically necessary.