

<b>Case Number:</b>	CM14-0076510		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	06/25/2002
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	05/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2014

### 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 50-year-old female was reportedly injured on June 25, 2002. The mechanism of injury was not listed in the records reviewed. The most recent progress note, dated May 12, 2014, was hand written and difficult to read. Another note, dated April 2, 2014, indicated that there were ongoing complaints of right upper extremity pain as well as right upper extremity hypersensitivity and swelling. The physical examination demonstrated extreme hypersensitivity throughout the right upper extremity. There was tenderness at the right acromioclavicular joint subacromial space, and rotator cuff muscles. Examination of the right wrist noted moderate swelling and tenderness of the extensor and flexor tendons. There was a positive Tinel's test and Phalen's test. Diagnostic imaging studies were not reviewed during this visit. Previous treatment included shoulder surgery, physical therapy, steroid injections, ganglion blocks, and oral medications. A request was made for Zonegran and was not medically necessary in the pre-authorization process on May 15, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zonegran:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Zonisamide (Zonegran).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 21 OF 127.

**Decision rationale:** ZONEGRAN is an antiepileptic medication. The California Chronic Pain Medical Treatment Guidelines support the use of antiepileptic medications for settings of neuropathic pain. According to the most recent progress note, dated April 2, 2014, the injured employee did have complaints of neuropathic symptoms, and there was objective documentation of this on physical examination. For this reason, this request for ZONEGRAN is medically necessary.