

<b>Case Number:</b>	CM14-0083514		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	02/14/2008
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	05/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2014

### 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 California. 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 59-year-old male who reported an injury on 02/14/2008 due to an unknown mechanism. Diagnoses were cervical failed back surgery syndrome, cervical radiculopathy, status post cervical spine fusion, headaches, depression, insomnia, vitamin D deficiency, and chronic pain (other). Past treatments were physical therapy and chiropractic sessions. Physical examination on 04/17/2014 revealed complaints of neck pain. The pain was reported to radiate down the bilateral upper extremity. The pain was rated a 9/10 in intensity with medications. The pain was rated a 10/10 in intensity without medications. The injured worker reported the pain was worse since his last visit. Cervical examination revealed spinal vertebral tenderness was noted in the cervical spine C4-7. The range of motion of the cervical spine was moderately limited due to pain. Medications were fentanyl transdermal, Lidoderm 5% patch, Opana, Senokot S, Tizanidine, vitamin D, Vicodin ES. Treatment plan was to continue medications as directed. The rationale and Request for Authorization were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Opana ER 40mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

**Decision rationale:** The request for Opana ER 40mg is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend short acting opioids. For ongoing management, there should be documentation of the "4 A's", including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The "4 A's" for ongoing management were not reported. The efficacy of this medication was not reported. The request does not indicate a frequency or a quantity for the medication. Therefore, this request is not medically necessary.

**Lidoderm 5% Patch:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylates, Topical Analgesics, Lidocaine Page(s): 105, 111, 112.

**Decision rationale:** The request for Lidoderm 5% Patch is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical salicylates are recommended, and topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines indicate that topical Lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an anti-epilepsy drug such as Gabapentin or Lyrica). No other commercially approved topical formulations of Lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. The efficacy of this medication was not reported. The request does not indicate a frequency or a quantity. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.

**Tizanidine 4mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The request for Tizanidine 4mg is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend Tizanidine (Zanaflex) as non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. The efficacy of this medication was not reported. The request does not indicate a frequency or a quantity for the medication. The clinical

information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.

**Vitamin D 2000:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

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

**Decision rationale:** The request for Vitamin D 2000 is not medically necessary. The Official Disability Guidelines state vitamin D is not recommended for the treatment of chronic pain based on recent research. Although it is under study as an isolated pain treatment, vitamin D supplementation is recommended to supplement a documented vitamin deficiency, which is not generally considered a Workers' Compensation condition. Musculoskeletal pain is associated with low vitamin D levels, but the relationship may be explained by physical inactivity and/or other confounding factors. Adjusting for these factors attenuated the relationship, although pain remained moderately associated with increased odds of 20% of having low vitamin D levels. The medical guidelines state that vitamin D deficiency is not generally considered a Workers' Compensation condition. The request does not indicate a frequency for the medication or a quantity. The efficacy of this medication was not reported. Therefore, this request is not medically necessary.