

<b>Case Number:</b>	CM14-0084840		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	02/08/2006
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	05/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/06/2014

### 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, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 55 year old female injured on 02/08/06 when involved in a motor vehicle collision. Specific injuries sustained were not provided in the clinical documentation. Diagnoses included disc disorder of the cervical spine and cervical radiculopathy. Clinical note dated 07/24/14 indicated the injured worker presented complaining of neck pain radiating into the left upper extremity unchanged from previous visits and poor quality of sleep. The injured worker reported following cervical fusion and discectomy on 03/04/14 significantly decreased headaches and pain in the right upper extremity; however continued to have left arm numbness and tingling. Physical examination of the cervical spine revealed restricted range of motion, paravertebral muscle tenderness bilaterally, motor strength 4/5 to bilateral upper extremities, hyperesthesia over lateral forearm bilaterally, decreased light touch and hyperesthesia to the left lateral forearm, and hyperesthesia on the left triceps. Medications included Celebrex 100mg twice a day, Zanaflex 4mg one half tablet every night Neurontin 400mg two tablets three times a day, Oxycontin 20mg one tablet three times a day, and oxycodone 15mg twice a day. The initial request for oxycodone 15mg #90, Oxycontin 20mg #90, Zanaflex 4mg #45 three refills, Neurontin 400mg #180 three refills and Celebrex #60 three refills was non-certified on 05/21/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone 15 MG # 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

**Decision rationale:** As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Oxycodone 15mg # 90 cannot be established at this time.

**Oxycontin 20 MG # 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

**Decision rationale:** As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Oxycontin 20mg # 90 cannot be established at this time.

**Zanaflex 4 MG # 45, 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

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

**Decision rationale:** As noted on page 63 of the Chronic Pain Medical Treatment Guidelines, muscle relaxants are recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the injured worker has exceeded the 2-4 week window for acute

management also indicating a lack of efficacy if being utilized for chronic flare-ups. As such, the medical necessity of Zanaflex 4mg # 45, 3 refills cannot be established at this time.

**Neurontin 400 MG # 180, 3 refills: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neurontin Page(s): 67.

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

**Decision rationale:** As noted in current California Medical treatment Utilization Schedule, Neurontin is recommended for the treatment of neuropathic pain. The clinical documentation establishes the presence of objective findings consistent with neuropathy. As such, the continued use of Neurontin 400mg # 180, 3 refills is appropriate and medically necessary.

**Celebrex # 60, 3 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs (NSAIDs) Page(s): 67.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Celebrex Page(s): 30.

**Decision rationale:** As noted on page 30 of the Chronic Pain Medical Treatment Guidelines, Celebrex is the brandname for celecoxib, and it is produced by Pfizer. Celecoxib is a non-steroidal anti-inflammatory drug (NSAID) that is a COX-2 selective inhibitor, a drug that directly targets cyclooxygenase-2 (COX-2), an enzyme responsible for inflammation and pain. NSAIDs are recommended as a second-line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute lower back pain. Package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). There is no documentation that these monitoring recommendations have been performed and the injured worker is being monitored on a routine basis. Additionally, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. As such, the request for Celebrex # 60, 3 refills cannot be established as medically necessary.