

<b>Case Number:</b>	CM15-0104228		
<b>Date Assigned:</b>	07/23/2015	<b>Date of Injury:</b>	09/06/2001
<b>Decision Date:</b>	08/25/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Anesthesiology

### 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 58 year old female who sustained an industrial injury on 09/06/2001. Current diagnoses include obesity, carpal tunnel syndrome, right knee chondromalacia patellae, status post right knee surgery on 02/25/2008, cervical sprain, lumbar sprain, status post left total knee arthroplasty, and ring and long trigger finger. Previous treatments included medications, surgical interventions, physical therapy, occupational therapy, weight loss program, psychotherapy, biofeedback, and Toradol injections. Previous diagnostic studies include urine toxicology screening. Initial injuries occurred to the left knee, back, and cervical spine after falling. Report dated 05/19/2015 noted that the injured worker presented with complaints that included aching pain in the right knee, and lower back. Pain level was 7 (right knee) and 8 (lower back) out of 10 on a visual analog scale (VAS). Current medication includes Tylenol #3, Gabapentin, Tizanidine, temazepam, Effexor, mirtazapine, and aspirin which are all helping. Currently she is not attending any therapy or working. Physical examination was positive for slow gait with heel and toe walk weakness, lumbar spine tenderness, spasm, and tightness, range of motion is reduced, mild decreased sensation over the L5 and S1 dermatomes, bilateral hand tenderness to the palm, decreased median sensation, decreased grip with pain, bilateral knee tenderness, pain with partial deep knee bend, and crepitus with motion. The treatment plan included administering a Toradol injection, prescriptions for ibuprofen for inflammation, Tizanidine for spasm, Restoril for sleep, Neurontin for neuropathic pain, Tylenol #3 for pain relief, and return in 6 weeks for re-evaluation. Disputed treatments include Gabapentin 300mg #120, acetaminophen with Codeine 300/30mg #60, Tizanidine 4mg #60, and Restoril 30mg #30.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Gabapentin 300mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs, Gabapentin Page(s): 17-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Gabapentin (Neurontin).

**Decision rationale:** According to the CA MTUS and the ODG, Neurontin (Gabapentin) is an anti-epilepsy drug (AED) which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The MTUS states that 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. The submitted documentation shows that the injured worker has been prescribed Neurontin since 2013. In this case, there was no documentation of subjective or objective findings consistent with current neuropathic pain to necessitate use of Neurontin. There were persistent neuropathic symptoms on the latest examination. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

### **Acetaminophen with Codeine 300/30mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Codeine (Tylenol with Codeine), Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional improvement, Codeine, Opioids section Page(s): 1, 35, 74-96.

**Decision rationale:** According to the California MTUS Guidelines, Tylenol with Codeine or Tylenol #3 is a short-acting opioid analgesic. It is recommended as an option for mild to moderate pain. Codeine is a schedule C-II controlled substance, but codeine with acetaminophen is a C-III controlled substance. It is similar to morphine. 60 mg of codeine is similar in potency to 600 mg of acetaminophen. It is widely used as a cough suppressant. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. The CA MTUS Guidelines define functional improvement as "a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management and a reduction in the dependency on continued medical treatment." In this case, the medical records submitted for review do not include the above recommended documentation. There is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. In addition, the request does not include dosing frequency or duration. Therefore the request for this medication is not medically necessary.

**Tizanidine 4mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain, Tizanidine (Zanaflex) Page(s): 63-65, 111.

**Decision rationale:** Tizanidine (Zanaflex) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and considered an adjunct treatment for fibromyalgia. Per the CA MTUS guidelines, Zanaflex is a muscle relaxant used as a second-line option for the short-term treatment of acute exacerbations in patients with chronic LBP. According to the guidelines, muscle relaxants have not been considered any more effective than non-steroidal anti-inflammatory drugs (NSAIDs) for pain or overall improvement. There is no additional benefit shown in combination with NSAIDs. In addition, sedation is the most commonly reported adverse effect of muscle relaxant medications. In this case, there has been long-term use of this medication without evidence of improvement in pain or functionality. The guideline criteria do not support the long-term (>2 wks) use of muscle relaxants. Medical necessity for the requested medication has not been established. The requested Tizanidine is not medically necessary.

**Restoril 30mg #30: 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 (Acute and Chronic), Insomnia Treatment.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia.

**Decision rationale:** Restoril (Temazepam) is an intermediate-acting 3-hydroxy hypnotic of the benzodiazepine class of psychoactive drugs. It is approved for the short-term treatment of insomnia. According to CA MTUS Guidelines, benzodiazepines are prescribed for anxiety. They are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. There are no guideline criteria that support the long-term use of benzodiazepines for sleep disturbances. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.