

Case Number:	CM15-0108366		
Date Assigned:	06/15/2015	Date of Injury:	05/07/2001
Decision Date:	08/05/2015	UR Denial Date:	05/30/2015
Priority:	Standard	Application Received:	06/05/2015

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 64 year old male, who sustained an industrial injury on 5/7/01. Initial complaints were not reviewed. The injured worker was diagnosed as having complex regional pain syndrome, Type II, upper limb; neck pain; brachial neuritis; primary fibromyalgia syndrome; backache; reflex sympathetic dystrophy lower extremity; open bimalleolar fracture. Treatment to date has included urine drug screening; medications. Currently, the PR-2 notes dated 10/22/14 indicated the injured worker complains of ongoing symptoms of chronic pain in the right elbow, right neck and upper back from guarding the right upper extremity. He is complaining of increased numbness in both shoulders and tingling fingers in both hands. He has developed painful left lateral epicondylitis due to states overuse, compensating for the right upper extremity. He is requesting a medication refill on this day. He wants to continue his medication as it is effective in reducing his pain, assisting in his activities of daily living and mobility as well as his restorative sleep. The provider reports the injured worker is on the lowest effective dose of the medications. On physical examination the provider notes a well-healed cervical to mid back scar for the placement of a spinal cord stimulator. He has tenderness to palpation of the paracervical, trapezius, levator scapulae and rhomboid and trapezius trigger point pain; swelling of soft tissue right lower anterior neck. He also has trigger points in his trapezius, rhomboid and levator scapulae which are quite pronounced. There is noted tenderness of the C6 and C7 spinaous process. Active range of motion elicits pain. His neurological examination notes sensation on the right: allodynia, hyperalgesia and hyperpathia throughout the right upper extremity worst around the area of the right elbow. Sensation of the left: allodynia, hyperalgesia and hyperpathia on the left upper extremity with more on the left elbow region. He also has erythema with some mottling of the skin in both upper extremities. He has a diagnosis

of complex regional pain syndrome, Type II of the upper extremities and reflex sympathetic dystrophy of the lower extremity. His has a spinal cord stimulator and it was no longer functioning properly and needed the battery and leads replaced. He was authorized for the removal of a spinal cord stimulator/leads and implantation of a new dual octrode spinal cord stimulator/leads and dual channel rechargeable implantable Pulse Generator with intraoperative and postoperative programming It is also noted the injured worker has signed a pain management agreement contract and documentation indicates he is consistent with prescription medication and no aberrant drug seeking behavior is evidenced. The provider is requesting authorization of Gabapentin 300mg #60; Gabapentin 600mg #120; Lidocaine patch 5% #45; Norco 10/325mg #120 and Tizanidine 4mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg quantity 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's functional benefit, return to work, random drug testing or opioid contract. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Tizanidine 4mg quantity 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63, 66.

Decision rationale: Zanaflex (Tizanidine) 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. According to CA MTUS 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 is no documentation of subjective or objective findings that indicate the medication has provided any relief. Also, the guideline criteria do not support the long-term use of muscle relaxants. Medical necessity for the requested medication has not been established. Zanaflex is not medically necessary.

Gabapentin 300mg quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin; Anti Epilepsy Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 17-19, 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. In this case, there was no documentation of any reduction in symptoms. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.

Gabapentin 600mg quantity 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin; Anti Epilepsy Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 17-19, 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. In this case, there was no documentation of any reduction in symptoms. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Lidocaine Patch 5% quantity 45: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 56-57.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics, such as the Lidoderm patch 5%, are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control, for example, NSAIDs, opioids, or antidepressants. Lidoderm is the brand name for a lidocaine patch. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants, or an AED, such as gabapentin or Lyrica). Lidoderm patches are not a first-line treatment and are only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. In this case, medical necessity of the requested item has not been established. The requested medication is not medically necessary.