

<b>Case Number:</b>	CM15-0184264		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	02/28/2005
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	09/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2015

### 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: Tennessee, Florida, Ohio  
 Certification(s)/Specialty: Surgery, Surgical Critical Care

### 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 54 year old female, who sustained an industrial injury on February 28, 2005. She reported cumulative work trauma. The injured worker was currently diagnosed as having brachial plexus lesions, post-laminectomy syndrome cervical, shoulder arthralgia-joint pain, spasm of muscle, constipation not otherwise specified, anxiety disorder not otherwise specified and depressive disorder not elsewhere classified. Treatment to date has included diagnostic studies, medication, surgery, injections and spinal cord stimulation train with no pain reduction. On September 14, 2015, the injured worker complained of discomfort in the neck and left upper extremity. She continued to report adequate pain relief with her current medication regimen and is able to complete activities of daily living. The treatment plan included medications, consultation with a medical internist and a follow-up visit. On September 18, 2015, utilization review denied a request for Gabapentin 300mg #270, Tizanidine 4mg #120 with one refill, Nortriptyline 10 mg #30 with one refill and Alprazolam 1mg #90 with one refill.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 300 mg, 270 count: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. MTUS Chronic Pain Guidelines note Gabapentin is an anti-epilepsy drug (AEDs -also referred to as anti-convulsants), 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 Guidelines recommend Gabapentin for patients with spinal cord injury as a trial for chronic neuropathic pain that is associated with this condition. The Guidelines also recommend a trial of Gabapentin for patients with fibromyalgia and patients with lumbar spinal stenosis. Within the provided documentation it did not appear the patient had a diagnosis of diabetic painful neuropathy or post herpetic neuralgia to demonstrate the patient's need for the medication at this time. Additionally, the requesting physician did not include adequate documentation of objective functional improvements with the medication or decreased pain from use of the medication in order to demonstrate the efficacy of the medication. Therefore, based on the submitted medical documentation, the request for Neurontin is not medically necessary.

**Tizanidine 4 mg, 120 count with one refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The MTUS Chronic Pain Medical Treatment Guidelines Section on Muscle Relaxants, page 66, states regarding Tizanidine, "Unlabeled use for low back pain...One study demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first-line option to treat myofascial pain... May also provide benefit as an adjunct treatment for fibromyalgia." The prior reviewer indicated that Tizanidine might only be indicated if there were spasms and may not be indicated on a chronic basis. While that recommendation may apply to other muscle relaxants, the specific recommendations in the treatment guideline for Tizanidine do clearly support its use for conditions such as fibromyalgia or myofascial pain which do not cause spasm and which are chronic conditions. The treatment guidelines do not support the use of Tizanidine as a first-line medication for this patient since the patient was not noted to have had muscle "twitches" with need for chronic pain control. Long term muscle relaxant use is not recommended. Therefore, based on the submitted medical documentation, the request for tizanidine is not medically necessary.

**Nortriptyline 10 mg, thirty count with one refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The California MTUS and the Official Disability Guidelines recommend that antidepressants can be utilized for the treatment of psychosomatic disorders associated with chronic pain syndrome. The records indicate that the patient denied the presence of depression, anxiety or any psychosomatic disorders. The patient reports that her current medication therapy allows her to perform her regular, daily activities. There is no indication that the patient's pain is more uncontrolled than in past clinic visits. There is also no documentation that the patient failed treatment with first-line preventive and chronic antidepressant pain medications prior to this prescription. Therefore, based on the submitted medical documentation, the request for pamelor (Nortriptyline) is not medically necessary.

**Alprazolam 1 mg, ninety count with one refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. Per the California MTUS guidelines, benzodiazepines are: "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks." This patient has been documented to have long-term, chronic neuropathic and musculoskeletal pain to the brachial plexus. Per MTUS, benzodiazepines should not be utilized for treatment of chronic pain. The patient has been prescribed Xanax for longer than 4 weeks and is at high risk for dependence. Therefore, based on the submitted medical documentation, the request for Xanax (Alprazolam) is not medically necessary.