

<b>Case Number:</b>	CM15-0022869		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	06/06/2011
<b>Decision Date:</b>	04/06/2015	<b>UR Denial Date:</b>	01/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 52-year-old female who reported an injury on 06/06/2011 due to an unspecified mechanism of injury. On 01/08/2015, she presented for a follow-up evaluation regarding her work related injury. She reported symptoms in the cervical spine, as well as chronic daily pain. She also stated that the pain would radiate into the upper trapezius and shoulder and was associated with numbness and intermittent occipital headaches. A physical examination showed that she had normal sagittal and coronal alignment of the cervical spine with decreased cervical lordosis. She also had tenderness to palpation over the right greater than left cervical paraspinal muscles, right inferior occiput, and right upper trapezius. There was also decreased range of motion in all planes of the cervical spine. She was diagnosed with chronic pain syndrome, cervical spinal stenosis, myofascial pain syndrome, history of anterior cervical discectomy and fusion, cervicogenic headaches with occipital neuralgia, depression and anxiety, gastroesophageal reflux disease, and intermittent insomnia due to pain. The treatment plan was for Norco, Voltaren gel, Topamax, and tizanidine. The rationale for treatment was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 5/325mg #60 with 3 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-going management, Weaning of medications.

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

**Decision rationale:** The California MTUS Guidelines state that an ongoing and documentation of pain relief, functional status, appropriate medication use, and side effects should be performed during opioid therapy. The documentation provided does not show that the injured worker was having a quantitative decrease in pain or an objective improvement in function with the use of this medication to support its continuation. Also, no official urine drug screens or CURES reports were provided for review to validate her compliance with her medication regimen. Furthermore, the frequency of the medication was not stated within the request and 3 refills would not be supported without a re-evaluation to determine treatment success. Therefore, the request is not supported. As such, the request is not medically necessary.

**Voltaren Gel #1 tube with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114.

**Decision rationale:** The California MTUS Guidelines indicate that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The documentation provided does not show that the injured worker was having a quantitative decrease in pain or an objective improvement in function with the use of this medication. Also, 3 refills would not be supported without a re-evaluation to determine treatment success. Furthermore, the frequency of the medication was not stated within the request and there was no indication that she had tried and failed recommended oral medications. Therefore, the request is not supported. As such, the request is not medically necessary.

**Topamax 50mg #90 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 21.

**Decision rationale:** The California MTUS Guidelines indicate that Topamax has been shown to have variable efficacy with failure to demonstrate efficacy in neuropathic pain but also states that it is still recommended for neuropathic pain when trials of other anticonvulsants have failed. There is a lack of documentation showing efficacy of this medication and a lack of evidence

showing that she had failed other recommended anticonvulsants. Also, 3 refills of this medication would not be supported without a re-evaluation to determine treatment success and the frequency was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

**Tizanidine 4mg #90 with 3 refills:** 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 Relaxant Page(s): 63.

**Decision rationale:** The California MTUS Guidelines recommend nonsedating muscle relaxants for the short term symptomatic relief of low back pain. Further clarification is needed regarding how long the injured worker has been using this medication. Without this information, continuing would not be supported as it is only recommended for short term treatment. Also, efficacy of this medication with a satisfactory quantitative decrease in pain and objective improvement in function was not clearly documented. Furthermore, the frequency was not provided within the request and the request for 3 refills of this medication would not be supported. Therefore, the request is not supported. As such, the request is not medically necessary.