

<b>Case Number:</b>	CM15-0041719		
<b>Date Assigned:</b>	03/11/2015	<b>Date of Injury:</b>	08/20/2012
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/05/2015

### 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: California  
 Certification(s)/Specialty: Emergency Medicine

### 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 35-year-old female who reported injury on 08/20/2012. The mechanism of injury was not provided. There was a Request for Authorization submitted for review dated 02/09/2015. The documentation of 01/30/2015 revealed the injured worker's diagnoses included carpal tunnel syndrome right, shoulder joint pain, tenosynovitis/synovitis hand, fibromyositis, and chronic pain syndrome. The injured worker indicated she had stiffness in her neck and had interference with sleep due to pain. There was radiation of pain to the middle of the right forearm which was unchanged with treatment. The injured worker had arthralgias in the right wrist and joint swelling of the right wrist. The injured worker stated she had extremity weakness in the right upper extremity. The physical examination revealed the injured worker had posture that was within normal limits. The medications included Colace 100 mg, Lidoderm 5%, Skelaxin 800 mg, Tylenol 325 mg, Tylenol extra strength 500, and Vicodin 5/300 mg as well as Voltaren 1% topical gel. The urine drug screen was noted to be within normal limits and the injured worker was noted to be CURES compliant. The treatment plan included a refill of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tylenol 325mg, #120 with 2 refills: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen Page(s): 11.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend Tylenol for the treatment of chronic pain and acute exacerbations of chronic pain. The efficacy was not provided nor was the objective functional benefit. There was a lack of documentation indicating the injured worker had a decrease in pain as pain was noted to be 10/10. There was a lack of documentation indicating a necessity for 2 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Additionally, there was a lack of documentation indicating the necessity for 2 products containing acetaminophen/Tylenol. Given the above, the request for Tylenol 325 mg #120 with 2 refills is not medically necessary.

**Vicodin 5/300mg, #45:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Medications for Chronic pain, Ongoing management.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker was being monitored for aberrant drug behavior. However, there was a lack of documentation of an objective decrease in pain and of objective functional benefit. There was a lack of documentation indicating the injured worker was being monitored for side effects. Additionally, there was a lack of documentation indicating the necessity for 2 products containing acetaminophen/Tylenol. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Vicodin 5/300 mg #45 is not medically necessary.

**Lidoderm patch #30 with 2 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56, 57.

**Decision rationale:** The California Medical Treatment & Utilization Schedule guidelines indicate that topical lidocaine (Lidoderm) 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). This is not a first-line treatment and is 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. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide documentation of a trial of first line therapy. There was a lack of documentation of objective functional benefit and objective decrease in pain with use of the medication. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 2 refills without re-evaluation. Given the above, the request for Lidoderm patch #30 with 2 refills is not medically necessary.

**Colace 100mg, #90 with 2 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Initiation of Opioid Therapy Page(s): 77.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines recommend that when initiating opioid therapy, prophylactic treatment of constipation should be initiated. The clinical documentation submitted for review failed to provide documentation of objective benefit and efficacy for the requested medication. There was a lack of documentation indicating a necessity for 2 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Colace 100 mg #90 with 2 refills is not medically necessary.

**Skelaxin 800mg, #30 with 2 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documented efficacy and functional benefit. There was a lack of documentation indicating a necessity for 2 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Skelaxin 800 mg #30 with 2 refills is not medically necessary.