

<b>Case Number:</b>	CM14-0118161		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	01/01/2002
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	07/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in Nevada. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 records presented for review indicate that this 63 year-old individual was reportedly injured on January 1, 2002. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated June 3, 2014, indicates that there are ongoing complaints of neck pain. The physical examination demonstrated a well-developed, well-nourished individual in mild distress. A decrease in cervical spine range of motion is reported. There is tenderness to palpation in the paraspinous musculature. Sensation is noted to be intact and motor function is described as 5/5. Diagnostic imaging studies objectified a barium swallow that noted impaired esophageal motility. Previous treatment includes cervical spine surgery, multiple medications, postoperative rehabilitation and pain management interventions a request had been made for multiple medications and was not certified in the pre-authorization process on July 23, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pantoprazole 20, #30.:** Overturned

**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 Page(s): 68 of 127.

**Decision rationale:** The records presented for review indicate compromised esophageal motility. As such, there is a need for this protein pump inhibitor. Based on the current clinical information a medical necessity has been established, and the request is medically necessary.

**Percocet 10/325mg, #90.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 116, Chronic Pain Treatment Guidelines Oxycodone/acetaminophen and Criteria for Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91 o.

**Decision rationale:** As outlined in the MTUS Guidelines, this is a short acting opioid indicated for the management of moderate to severe breakthrough pain. However, it appears this medication is being prescribed on a constant, indefinite, chronic basis. Furthermore, there is nothing in the progress notes to suggest that this medication is demonstrating any efficacy or utility in terms of increased functionality or decreased symptomology. As such, the request is not medically necessary.

**Tizanidine HCL 2mg, #60.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/antispasmodic drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66 of 127.

**Decision rationale:** As outlined in the MTUS Guidelines, this medication is approved by the FDA for the management of spasticity. This individual has undergone cervical spine surgery and there is no objectified spasticity. There are muscle spasms noted upon palpation of the posterior cervical spine musculature, however, this medication is not indicated for that use. As such, the request is not medically necessary.

**Voltaren 1% gel, #400.:** 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 Page(s): 111,112.

**Decision rationale:** Voltaren gel is a topical NSAID indicated for the relief of osteoarthritic pain of the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. Outside of the treatment of osteoarthritis, there's no other clinical indication for the use of this medication. There is no documentation of osteoarthritis in the clinical notes provided. As such, this request is not medically necessary

**Klonopin 0.5mg, #30.:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

**Decision rationale:** Clonazepam (Klonopin) is a benzodiazepine used for the treatment of anxiety, seizures, neuralgia, and periodic leg movement disorder. It is not recommended for long term use. Further, as noted in the MTUS, this is not recommended due to rapid development of tolerance and dependence issues. There is little benefit in the use of this class of medications over non-benzodiazepines in the treatment of spasms. As such, the request is not medically necessary.