

<b>Case Number:</b>	CM14-0123261		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	04/28/2011
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	07/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/05/2014

### 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 has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 58-year-old male who reported an injury on 04/28/2011, due to an unknown mechanism. Diagnosis was right foot pain, hallucis valgus deformity, narrowing at the 1st and 2nd metatarsophalangeal joint. X-rays of the left foot, mild hallucis valgus deformity and mild narrowing at the 1st metatarsophalangeal joint space, small calcaneal spur. Past treatments were not reported. Diagnostic studies were CT of the right foot, x-ray lumbar spine, MRI lumbar spine, x-rays of both feet. Past surgical history was not reported. Physical examination on 06/09/2014, there were complaints of bilateral foot pain, worse on the right side. The injured worker was awaiting approval for surgery for the right foot. Objective findings were noted as no significant changes. Medications were Percocet 10/324 four a day, Ibuprofen 800 mg 1 tablet twice a day, Zanaflex 4 mg 1 twice a day, Neurontin 600 mg one 3 times a day. The treatment plan was to await surgical decision, continue medications as prescribed. The rationale and Request for Authorization were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Norco Page(s): 75.

**Decision rationale:** The request for Norco 10/325 mg quantity 120 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend short acting opioids, such as Norco, for controlling chronic pain. For ongoing management, there should be documentation of the 4 A's including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for a medication. Therefore, the request for Norco 10/325mg #120 is not medically necessary.

**Zanaflex 4mg #60:** Upheld

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

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

**Decision rationale:** The request for Zanaflex 4 mg quantity 60 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend Tizanidine (Zanaflex) as a non-sedating muscle relaxant with caution a second line option for short term treatment for acute exacerbations in patients with chronic low back pain. The efficacy of this medication was not reported. Also, the frequency for this medication was not indicated on the request. Therefore, the request for Zanaflex 4 mg quantity 60 is not medically necessary.

**Neurontin 600mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Specific Drug List, Gabapentin Page(s): 16.

**Decision rationale:** The request for Neurontin 600 mg quantity 90 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that gabapentin is shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request for Neurontin 600 mg quantity 90 is not medically necessary.