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| <b>Case Number:</b>   | CM15-0067820 |                              |            |
| <b>Date Assigned:</b> | 05/13/2015   | <b>Date of Injury:</b>       | 01/09/1999 |
| <b>Decision Date:</b> | 06/11/2015   | <b>UR Denial Date:</b>       | 04/08/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/09/2015 |

### 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: New Jersey

Certification(s)/Specialty: Family Practice

### 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 57 year old male who sustained an industrial spinal cord injury on 01/09/1999 secondary to a fall from a roof. The injured worker was diagnosed with a C3 lamina fracture with small fractures of the anterior superior margins of C4 with ligamentous instability and a C7 spinous process fracture. The injured worker underwent a posterior cervical fusion with Halifax clamps and arthrodesis from C3-C5. The injured worker is also is status post lumbar spine surgery in September 2006, hardware removal in 2008 and right shoulder arthroscopy in 2010 and on January 22, 2014. The injured worker is diagnosed with chronic pain syndrome, neuropathic pain syndrome with central neurogenic dysesthesias with right sided hyperreflexia, right upper extremity spasticity, incoordination and weakness, sleep disorder, gastroesophageal reflex disorder (GERD), and chronic headaches. Treatment to date includes multiple diagnostic testing of the cervical and lumbar spine and right shoulder, multiple surgeries, epidural steroid injection, physical therapy, acupuncture therapy and medications. According to the primary treating physician's progress report on March 10, 2015, the injured worker continues to experience headaches which radiate to the neck and associated with nausea, vomiting and photophobia rated at 2/10 currently and 10/10 at their worst. The injured worker reports continued right shoulder pain from the lateral distal arm to the superior shoulder and neck area rated at a 6-7/10. His low back pain radiates to the left leg to the bottom of the foot, described as burning and throbbing pain, which he rates as 2/10 currently at the office and increases to 10/10 with sitting or walking greater than 30 minutes. Examination demonstrated severe limitation in active range of motion especially extension and left lateral rotation. Shoulders have decreased

range of motion with right hand and left leg hyperapathia/allodynia. Neurological testing demonstrated right sided Horner's. The right upper limb has hypotrophic musculature in comparison to the left with right sided hyperreflexia present. Right side shows intrinsic weakness in comparison to the left side. Straight leg raise is positive on the left. Current medications are listed as OxyContin, Klonopin, Lidocaine cream, Prevacid and shoulder and lower back topical analgesics. Treatment plan consists of adding Midrin equivalent for chronic headaches, awaiting further magnetic resonance imaging (MRI) studies of bilateral shoulder and cervical spine performed on March 10, 2015, current medication regimen and the current request for Klonopin and Lidocaine.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **1 prescription for Klonopin 0.5mg: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** The MTUS Guidelines for Chronic Pain state that benzodiazepines are not recommended for long-term use due to their risk of dependence, side effects, and higher tolerance with prolonged use, and as the efficacy of use long-term is unproven. The MTUS suggests that up to 4 weeks is appropriate for most situations when considering its use for insomnia, anxiety, or muscle relaxant effects. In the case of this worker, the Klonopin was used nightly to help with anxiety and sleep. However, the recent note provided for review suggested that the worker found the Klonopin to not help much with the sleep or anxiety with its regular use. Regardless, this medication is not recommended to be used chronically as it had been used and is being requested to be used moving forward. Therefore, the request for Konopin will not be considered medically necessary at this time. Also, the number of pills requested was not included in the request. Weaning may be indicated.

#### **1 prescription of Lidocaine 3%: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications, Lidocaine, topical.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** The MTUS Guidelines for Chronic Pain state that topical lidocaine is not a first-line therapy for chronic pain, but may be recommended for localized peripheral neuropathic pain after there has been evidence of a trial of first-line therapy (including tri-cyclic, SNRI anti-depressants, or an AED such as gabapentin or Lyrica). Topical lidocaine is not recommended for non-neuropathic pain as studies showed no superiority over placebo. The past two progress notes leading up to this request in the case of this worker showed a

prescription for gabapentin to be trialed to help treat the neuropathic pain related to his injury. However, there was no documentation which revealed if the worker tried this medication and if so whether or not it helped and by how much. If it was not trialed yet, then considering Lidocaine before using gabapentin first would be premature and inappropriate, considering the Guidelines. Therefore, the request for lidocaine 3% will not be considered medically necessary at this time.