

<b>Case Number:</b>	CM13-0036875		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	04/06/2010
<b>Decision Date:</b>	02/20/2014	<b>UR Denial Date:</b>	10/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine, and is licensed to practice in Texas. 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 physician 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 patient is a 63-year-old female who sustained a work-related injury on 4/6/10. The patient's diagnoses include right shoulder impingement syndrome with AC joint arthrosis, left shoulder impingement syndrome with AC joint arthrosis, bilateral carpal tunnel release, and status post laminectomy lumbar spine with intermittent bilateral sciatica. Subjectively, the patient reported complaints of intermittent bilateral shoulder pain exacerbated by physical movement. Objectively, the patient had a positive Hawkins test bilaterally, a positive Neer's test bilaterally, decreased strength at 4/5 with supraspinatus isolation bilaterally, and tenderness of the AC joint bilaterally with positive cross body adduction movement. The patient's medications included Norco, naproxen, Omeprazole, Tizanidine, Lyrica, Lidoderm patches 5%, and Medrox cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**90 Tizanidine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63,66.

**Decision rationale:** The California MTUS guidelines indicate that Tizanidine is FDA approved for management of spasticity and has an unlabeled use for low back pain; however, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations of chronic low back pain. The clinical information submitted for review lacks objective documentation of functional improvement or medication efficacy with the use of the requested medication. Additionally, there is lack of documentation that the patient has attempted and failed first line treatment. \As such, the request is non-certified.

**Lidoderm 5%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

**Decision rationale:** The California MTUS guidelines recommend the use of Lidocaine in a dermal patch formulation for neuropathic pain after there has been evidence of a trial of first-line therapy like tri-cyclic or SNRI anti-depressants, or an AED such as Gabapentin or Lyrica. The clinical information submitted for review indicates the patient was on Lyrica, but it lacks objective documentation of lack of medication efficacy. Additionally, the clinical notes further lack objective documentation of medication efficacy with the use of the requested medication. Given the lack of documentation submitted for review, the request cannot be validated. Therefore, the request is non-certified.

**120 grams of Medrox cream:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

**Decision rationale:** The California MTUS guidelines "recommend the use of capsaicin only as an option in patients who have not responded or are intolerant to other treatments in formulations of 0.025% as a treatment for osteoarthritis, and 0.075% for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain." Medrox contains Capsaicin in a formulation of 0.0375%. There have been no studies of a 0.0375% formulation of Capsaicin, and there was no current indication that the increase over a 0.025% formulation would provide any further efficacy. Furthermore, guidelines also state that if one of the medications in a compound is not recommended, that the topical compound as a whole cannot be recommended. The clinical information submitted for review lacks objective documentation that the patient is intolerant to or has not responded to other treatments and has had functional improvement, or that the requested medication has provided sufficient pain reduction. Given the above, the request is not supported. As such, the request is non-certified.