

<b>Case Number:</b>	CM13-0041318		
<b>Date Assigned:</b>	03/03/2014	<b>Date of Injury:</b>	12/04/2007
<b>Decision Date:</b>	06/10/2014	<b>UR Denial Date:</b>	10/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/11/2013

### 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 & Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 patient is a 50-year-old female with date of injury of 12/04/2007. According to the report, the patient complains of increased low back pain. She describes tingling in the lower extremities, shoulders, buttock, and posterior thighs. She denies any sharp shooting pain that radiates into the lower extremities. She reports that her muscle spasms have improved and she is taking less tizanidine. She notes pain in the right shoulder and knees. Her current medication regimen includes Norco, tizanidine, amitriptyline, Prilosec, Laxacin, ketoprofen, gabapentin, and lidocaine. The patient rates her pain a 7/10 with the use of medications and 10/10 without her medications. The patient is reporting adequate pain control with use of medication and medications have been beneficial in reducing her pain, so that she is able to function. She is also able to perform her activities of daily as well as return to work on a part time basis without restrictions. The patient denies any intolerable side effects other than GI symptoms. Physical examination shows there is tenderness to palpation of the bilateral cervical paraspinal region with 1+ palpable muscle spasm. Range of motion is stiff with negative Spurling's. Sensory exam shows both upper extremities are intact to light touch and pinprick.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TIZANIDINE 4MG #30:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY/ANTISPASMOTICS,.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY/ANTISPASMODIC DRUGS.

**Decision rationale:** The MTUS Guidelines indicate that tizanidine is a centrally acting alpha1-adrenergic agonist that is FDA approved for management of spasticity with an unlabeled use for low back pain. In addition, it demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome. The review of records showed that the patient has been using tizanidine since April 2013. The MTUS guidelines p60 and 61 require evaluation of the effect of pain relief in relationship to improvements in function and increased activity when using medications for chronic pain. The treating physician documents on 09/12/2013 that the prescription for tizanidine is a decreased dose and is to be used for acute spasms only. The treating physician also documents that the muscle spasms have improved, and the patient is taking less tizanidine. In this case, the patient does report significant improvement with the use of Tizanidine. Recommendation is for authorization.

**VOLTAREN GEL 1%:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS.

**Decision rationale:** The MTUS Guidelines state that topical analgesics are largely experimental when used with few randomized controlled trials to determine efficacy or safety. In addition, they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Voltaren gel is indicated for relief of osteoarthritis pain and joints that lend themselves to topical treatment (elbow, foot, hand, knee, and wrist). Topical NSAIDs also has not been evaluated for treatment of spine, hip, or shoulder. In this case, the patient suffers from chronic knee pain due to patellofemoral syndrome. Recommendation is for authorization.

**COMPOUND MEDICATION KETOPROFEN/ GABAPENTIN/ LIDOCAINE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111.

**Decision rationale:** The MTUS Guidelines state that topical analgesics are largely experimental and used with few randomized controlled trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have

failed. MTUS further states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, gabapentin and ketoprofen are not recommended as topical compounds per MTUS Guidelines. Recommendation is for denial.