

Case Number:	CM13-0056949		
Date Assigned:	12/30/2013	Date of Injury:	02/10/2004
Decision Date:	04/01/2014	UR Denial Date:	11/20/2013
Priority:	Standard	Application Received:	11/25/2013

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 Internal Medicine, has a subspecialty in Pulmonary Disease and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working least at 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 57-year-old female who reported injury on 02/10/2004. The mechanism of injury was noted to be while drawing blood from a patient who was somewhat uncooperative and required some restraint. The patient was bending over the bedrails and struck her left knee against some portion of the bed resulting in local pain. There was noted to be a second incident on 11/11/2004; while at a patients' bedside, she called a code blue and no one responded, and the patient ran to the emergency room for help and slipped and fell, injuring her back and left knee. The patient's medications as of 03/19/2013 included Lortab, Zanaflex, and Lidoderm patches. On 05/14/2013, the physician added Biofreeze cream. On 10/30/2013, the patient indicated that the Lidoderm patches were helpful quite a bit. The patient had low back pain with radiating symptoms to the lower extremities. The diagnoses were noted to be chronic low back pain syndrome and postlaminectomy syndrome with a history of discectomy/ laminectomy at L4-5 in 07/2006. The plan was noted to be the patient should try Effexor x-ray 37.5 mg at nighttime to see if it helped with neuropathic pain. It was indicated for the patient to use a Lidoderm patch; she had yet to fail anticonvulsants or antidepressants, and other neuropathic pain medications. The patient was given a refill of other medications, as they were helpful, and allowed the patient to be active and functional. The request was made for medication refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4mg #30: 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.

Decision rationale: California MTUS Guidelines recommend muscle relaxants as a second-line option for short-term treatment of acute low back pain. The usage is for less than 3 weeks. There should be documentation of objective functional improvement. Clinical documentation submitted for review indicated the patient had been taking the medication since 03/2013. There was a lack of documentation of objective functional improvement. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for Zanaflex 4 mg #30 is not medically necessary.

Lidoderm patches 5% #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56 and 57.

Decision rationale: California MTUS guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an anti-epileptic drug (AED) such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Clinical documentation submitted for review failed to indicate the patient had trialed and failed first-line treatment. The physician indicated they were recommending Effexor X-RAY 37.5 mg at nighttime to see if it helped with neuropathic pain. Given the above, and the lack of documentation of failure of a first-line therapy, the request for Lidoderm patches 5% #30 is not medically necessary.

Biofreeze roll on gel, two (2) bottles: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105..

Decision rationale: California MTUS Guidelines indicate that topical salicylates are approved for chronic pain. There should be documentation of objective functional improvement or continuation of therapy. There was a lack of documentation indicating the patient had a

necessity for 2 bottles of Biofreeze roll-on gel. There was a lack of documentation of the efficacy of the requested medication, as the medication was noted to have been added to treatment on 05/14/2013. Given the above, the request for Biofreeze roll-on gel, 2 bottles, is not medically necessary.