

<b>Case Number:</b>	CM14-0002655		
<b>Date Assigned:</b>	01/29/2014	<b>Date of Injury:</b>	04/20/1998
<b>Decision Date:</b>	06/19/2014	<b>UR Denial Date:</b>	01/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2014

### 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 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 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 71 year old female injured on 04/20/98 due to an undisclosed mechanism of injury. The documentation indicates the injured worker's current diagnoses as post-laminectomy syndrome of the lumbar spine, lumbar radiculopathy, and lumbar/lumbosacral disc degeneration. The clinical note dated 12/18/13 indicates the injured worker was scheduled for a neck fusion on 01/14/14; however, there is no additional documentation to indicate the injured worker underwent surgical intervention. The clinical note dated 04/09/14 indicates the injured worker's chief complaint is low back pain, right radicular pain, insomnia secondary to pain, neuropathic low back pain with burning, allodynia, and Anheuser sensitivity in the skin of the lumbar spine. It is noted the injured worker has previously undergone L3-4, L4-5 spinal surgery which was ineffective in relieving pain. The injured worker did report significant relief of pain and improvement in activities of daily living with the use of medications. There were no VAS pain scores provided in the documentation. Medications include Bisacodyl 5mg TID, Lidoderm 5% 2 patch Q 12 hours, Oxycodone 20mg 3 tablets BID, Oxycodone/Acetaminophen 10/325mg Q 4 hours, Temazepam 30mg QHS, and Zyrtec 10mg QD. Physical examination revealed an antalgic gait, pain and difficulty with transfers from sitting to standing, sensitivity to light touch in the right lumbosacral spine, decreased range of motion for flexion and extension, paraspinous muscle tenderness without spasm, range of motion grossly normal for major joints.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LIDOCAINE 5% 700MG/PATCH #120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN GUIDELINES, , 56-57.

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

**Decision rationale:** As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Lidoderm is recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Lidoderm is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. Therefore, Lidocaine 5% 700mg/Patch #120 cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

**TEMAZEPAM 30MG #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN GUIDELINES, BENZODIAZEPINES, 24, 66.

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

**Decision rationale:** As noted on page 24 of the Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The patient has exceeded the 4 week treatment window. As such, the request for Temazepam 30mg #60 cannot be recommended at this time.

**ZYRTEC 10MG #120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.rxlist.com/zyrtec-drug.htm>.

**Decision rationale:** Zyrtec is utilized in the treatment of seasonal allergic rhinitis, perennial allergic rhinitis, and chronic urticaria. The clinical documentation indicates the patient utilizes the medication for rash caused by current medication use; however, there is no indication of

attempts to alter medication regimen due to possible allergic reaction. Additionally, this medication is readily available in a generic over-the-counter formulation. As such, the request for Zyrtec 10MG #120 cannot be recommended as medically necessary at this time.