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| <b>Case Number:</b>   | CM14-0005808 |                              |            |
| <b>Date Assigned:</b> | 02/05/2014   | <b>Date of Injury:</b>       | 06/01/2013 |
| <b>Decision Date:</b> | 06/20/2014   | <b>UR Denial Date:</b>       | 12/31/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/13/2014 |

### 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, 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 patient is a 34 year old female injured on 06/01/13 due to an undisclosed mechanism of injury. Current diagnoses included right elbow lateral epicondylitis, lumbar spine sprain, persistent axial low back pain with arthropathy, mild lumbar spondylosis with facet changes, and left knee strain. The clinical documentation dated 12/03/13 indicated the patient was evaluated in the emergency department for low back pain rated at 8/10. The patient was treated with valium, Dilaudid, and Zofran and discharged to home. A clinical note dated 12/26/13 indicated the patient reported left sided low back pain and left knee pain. The patient reported pain interfered with her activities of daily living and ability to sleep. Medications included Relafin, Tizanidine, and Tramadol. The patient was evaluated on multiple occasions in the emergency department for excessive pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ZANAFLEX 4MG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 63

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

**Decision rationale:** As noted on page 63 of the MTUS Chronic Pain Guidelines, muscle relaxants are recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the patient has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. As such, the request is not medically necessary and appropriate.

**COMPOUND FLURIFLEX:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 111-113

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

**Decision rationale:** As noted on page 111 of the MTUS Chronic Pain Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, the MTUS Chronic Pain Guidelines require that all components of a compounded topical medication be approved for transdermal use. Therefore the request for Fluriflex cannot be recommended as medically necessary as it does not meet this criteria. The request is not medically necessary and appropriate.