

Case Number:	CM14-0123998		
Date Assigned:	08/08/2014	Date of Injury:	03/16/1995
Decision Date:	09/24/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/05/2014

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 Internal Medicine, has a subspecialty in Rheumatology and is licensed to practice in Maryland. 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 71 year old female with date of injury 3/16/1995. The mechanism of injury is not stated in the available medical records. The patient has complained of lower back pain with intermittent radiation of pain to the bilateral lower extremities since the date of injury. She has been treated with lumbar spine surgery (decompression and fusion), physical therapy and medications. MRI of the lumbar spine dated 04/2014 revealed findings consistent with post laminectomy at L3-L4, moderate bilateral neuroforaminal narrowing at L3-5 and moderate central canal stenosis with severe bilateral neuroforaminal narrowing at T12-L1. Objective: painful and decreased range of motion of the lumbar spine, tenderness to palpation of the lumbar spine, decreased sensation to light touch bilateral anterior thighs, mild decrease in strength of the bilateral hip flexors and gastrocnemius musculature. Diagnoses: lumbar spine degenerative disc disease, lumbar spine stenosis, lumbar strain. Treatment plan and request include: Tizanidine, Lyrica, Talwin, and Lidoderm 5%.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 4 mg, Quantity 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, page 41 Page(s): 41.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Page 41. The Expert Reviewer's decision rationale: Per the MTUS guidelines cited above, "Muscle relaxant agents (Zanaflex) are not recommended for chronic use and should not be used for greater than 2-3 weeks in duration. Additionally, they should not be used with other agents. On the basis of these MTUS guidelines, Zanaflex is not indicated as medically necessary.

Lyrica 50mg, Quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin, page 99 Page(s): 99.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Page 99. The Expert Reviewer's decision rationale: Pregabalin (Lyrica) has been documented to be effective in treatment of diabetic neuropathy and post-herpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. Pregabalin was also approved to treat fibromyalgia. There is no documentation in the available medical records of any of these conditions nor is there a discussion of the rationale regarding use of this medication. On the basis of the MTUS guideline cited above and the available medical documentation, Lyrica is not indicated as medically necessary.

Talwin 100mg, Quantity 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-79.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, pages 76-85, 88-89 Page(s): 76-85, 88-89.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Opioids, criteria for use, Pages 76-85, 88-89. The Expert Reviewer's decision rationale: There were no treating physician reports that adequately assessed the patient with respect to function, specific benefit, return to work, signs of abuse or treatment alternatives other than opioids. There is also no evidence that the treating physician is prescribing opioids according to the MTUS section cited above which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opioid contract and documentation of failure of prior non-opioid therapy. On the basis of this lack of documentation and failure to adhere to the MTUS guidelines, Talwin is not indicated as medically necessary.

Lidoderm 5% patch, Quantity 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm patch, pages 56-57 Page(s): 56-57.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Pages 56-57. The Expert Reviewer's decision rationale: Per the MTUS guideline cited above, "Topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of failure of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica)." There is no documentation evidence of a trial and failure of a trial of one of these medications in the available medical records. On the basis of the MTUS guidelines, Lidoderm patch is not indicated as medically necessary.

Celebrex 200mg, Quantity 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68, 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, pages 67-68 Page(s): 67-68.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, NSAIDS, Pages 67-68. The Expert Reviewer's decision rationale: Per the MTUS guideline cited above, "NSAIDS are recommended for the short term (2-4 week) symptomatic relief of low back pain." The current request is for continuation of treatment exceeding the recommended treatment period for this medication. On the basis of the MTUS guidelines, Celebrex is not indicated as medically necessary.