

Case Number:	CM14-0023738		
Date Assigned:	06/16/2014	Date of Injury:	04/28/2008
Decision Date:	08/11/2014	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	02/25/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in California and Washington. 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 49-year-old female who reported an injury on 04/28/2008. The mechanism of injury was not provided for clinical review. The diagnoses include lumbago, degeneration of the lumbar or lumbosacral intervertebral disc, post laminectomy syndrome lumbar region, myalgia, chronic pain syndrome, sacroiliac joint pain, piriformis syndrome. Treatments include stretching exercises, heat/ice, and medication. In the clinical note dated 04/10/2014, it was reported the injured worker complained of low back and leg pain. The injured worker described her pain as constant, throbbing ache with occasional stabbing of the left buttock and lumbosacral area. The worker complained of burning in the posterior aspect of her left leg. She rated her pain as 7/10 out of 10 in severity. Upon the physical examination of the lumbar spine, the provider noted the diminished sensation along the posterolateral aspect of the left lower extremity at L5-S1 dermatome. Painful to palpation, left greater than right, in the sciatic notches. Tenderness of the sacroiliac joint, left greater than right. Trick sign and Gaenslen maneuver were positive bilaterally. The injured worker had a positive straight leg raise on the left and negative on the right. The provider requested Flexeril, Terocin patches for chronic, intractable pain. However, a rational was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLEXERIL 10MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): age(s) 63, 64.

Decision rationale: The request for Flexeril 10 mg #90 is not medically necessary. The injured worker complained of low back and left leg pain. She described her pain as constant throbbing, ache, with occasional stabbing in her left buttock and lumbosacral area. She rated her pain 7/10 in severity. The California MTUS Guidelines recommend nonsedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The guidelines state that the medication is not recommended to be used for longer than 2 to 3 weeks. There is lack of significant objective findings indicating the injured worker was treated for a diagnosis of muscle spasms. The injured worker has been utilizing the medication for an extended period of time since at least 10/2013, which exceeds the guideline recommendations of short term use of 2 to 3 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

TEROCIN 120ML#1 FOR THE LUMBAR SPINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: The request for Terocin 120 mL #1 for the lumbar spine is not medically necessary. The injured worker complained of low back and left leg pain. She described her pain as constant throbbing, ache, with occasional stabbing in her left buttock and lumbosacral area. She rated her pain 7/10 in severity. California MTUS Guidelines noted topical NSAIDs are recommended for the use of osteoarthritis and tendinitis and in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is little evidence to utilize NSAIDs for treatment of osteoarthritis of the hips, spine, or shoulder. Terocin lotion contains methyl salicylate, Capzasin, menthol, and lidocaine. Capzasin is only recommended as an option in patients who do not respond or are intolerant to other medications. Topical lidocaine is recommended for neuropathic pain and localized peripheral pain after there has been evidence of a trial of first line therapy. Topical lidocaine in the formulation of a dermal patch, Lidoderm, has been designated for orphan status by the FDA for neuropathic pain. There is lack of documentation indicating the injured worker has not responded or is intolerant to other treatments. There is lack of documentation indicating the injured worker tried and failed on first line agents for the management of neuropathic pain. The injured worker has been utilizing the medication for an extended period of time, since at least 10/2013, which exceeds the guideline recommendations of 4 to 12 weeks. The request submitted failed to provide the frequency of the medication. The clinical documentation

submitted failed to provide the efficacy of the medication as evidenced by significant functional improvement. Therefore, the request is non-medically necessary.