

<b>Case Number:</b>	CM14-0028246		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	11/18/2010
<b>Decision Date:</b>	07/21/2014	<b>UR Denial Date:</b>	02/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/05/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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:

This is a patient with a date of injury of 11/18/10. A utilization review determination dated 2/24/14 recommends non-certification of tizanidine, Lidoderm, and "Lyclo-Keto-Lido" cream. It references a 1/22/14 medical report identifying that Lidoderm was only mildly helpful and the patient cannot take NSAIDs due to gastritis and cannot take acetaminophen due to "increased liver functions tests." Tramadol has been tried and the patient does not like the side effect of drowsiness. 5/21/14 medical report identifies chest pain, intermittent numbness and tingling of the left upper extremity, weakness of the LUE, nausea at times, intermittent dizziness, intermittent lightheadedness, and intermittent bilateral blurred vision. No abnormal exam findings are noted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TIZANIDINE 150MG #30 X3 REFILLS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (2009) Page(s): 63-66.

**Decision rationale:** Regarding the request for tizanidine, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the tizanidine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested tizanidine is not medically necessary.

**LIDODERM PATCHES 5% #2 BOXES X3 REFILLS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Web edition.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (2009) Page(s): 111-113.

**Decision rationale:** Regarding the request for Lidoderm Patches 5% #2 boxes x3 refills, California MTUS cites that topical lidocaine is "recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or selective serotonin and norepinephrine reuptake inhibitors (SNRI) anti-depressants or an anti-epilepsy drug (AED) such as gabapentin or Lyrica)." within the documentation available for review, none of the abovementioned criteria have been documented, as there is no indication of a localized peripheral area of neuropathic pain and failure of first-line therapy. in the absence of such documentation, the currently requested Lidoderm Patches 5% #2 boxes x3 refills is not medically necessary.

**LYCLO-KETO-LIDO CREAM #240GM X3 REFILLS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (2009) Page(s): 111-113.

**Decision rationale:** Regarding the request for Lyco-Keto-Lido Cream #240gm X3 refills, this appears to be cyclobenzaprine/ketoprofen/lidocaine cream. California MTUS cites that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Topical ketoprofen is "not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis." Topical lidocaine is "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 AED such as gabapentin or Lyrica)." Additionally, it is supported

only as a dermal patch. Muscle relaxants are not supported by the CA MTUS for topical use. Within the documentation available for review, none of the above mentioned criteria have been documented. In light of the above issues, the currently requested Lyclo-Keto-Lido Cream #240gm X3 refills is not medically necessary.