

Case Number:	CM14-0041013		
Date Assigned:	07/07/2014	Date of Injury:	12/06/1999
Decision Date:	08/14/2014	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	04/07/2014

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 Family Medicine, and is licensed to practice in North Carolina. 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 68 -year-old with a date of injury of 12/6/99. The patient has the diagnoses of C4-5 and C5-6 degenerative disc disease, C4-5 and C5-6 moderate foraminal stenosis, right shoulder impingement syndrome, and right arm radiculopathy. Per the progress notes provided by the primary treating physician, dated 12/10/13, the patient complains of ongoing neck pain extending into the right shoulder which is rated at 7/10, as well as right thumb pain. The physical exam noted tenderness and spasm of the paracervical muscles and right trapezius muscle. There was also noted decreased range of motion. The treatment plan consisted of renewal of chronic medications as well as request for physical therapy and consideration for cortisone injection into the trigger finger.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 2mg #30 with 5 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC Pain Procedure Summary Last Updated 01/07/2014.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-65.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines state that non-sedating muscle relaxants are recommended with caution as a second-line option for the short-term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity, and has an unlabeled use for low back pain. Eight studies have demonstrated efficacy for low back pain. One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. It may also provide benefit as an adjunct treatment for fibromyalgia. Though the patient is currently undergoing a flare-up of pain, this medication has been used chronically. As such, the request is not medically necessary.

Naproxen Sodium 550mg #60 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period of time in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. The long-term use of this class of medication is not recommended and thus the medication cannot be recommended for chronic, long-term use. The request is not medically necessary.

Lidoderm 5% Patches #60 with 5 refills: Upheld

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

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

Decision rationale: The California Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas

with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Lidocaine is indicated for neuropathic pain for localized peripheral pain after first-line therapies, including tri-cyclics, SNRIs, or AEDs have been trialed. There is no documentation of failure of a first line treatment. As such, the request is not medically necessary.