

<b>Case Number:</b>	CM14-0046497		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	02/20/1998
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	03/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/15/2014

### 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 Occupational Medicine 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:

The patient is a 51-year-old female who has submitted a claim for thoracic strain, lumbar strain, associated with an industrial injury date of February 20, 1998. Medical records from 2013 through 2014 were reviewed. The latest progress report, dated 03/06/2014, showed persistent mid and low back pain that was generally slight to mild at rest but became moderate when working. Physical examination revealed tenderness along the cervical paraspinal muscles. There was mildly restricted range of motion with cervical rotation. The thoracic range of motion was restricted due to increased pain. There was tenderness along the thoracic paraspinal muscles. There was restricted range of motion for the lumbar spine due to increased pain. There was tenderness along the lumbar paraspinal muscles. Seated leg raising and supine leg raising tests were negative. Treatment to date has included home exercise and medications such as Lidoderm patch, Zanaflex and Ketoprofen gel which have been prescribed since June 2013. Utilization review from 03/18/2014 denied the request for the purchase of Zanaflex 4mg bid #60 because the submitted documentation did not identify significant functional/vocational benefit with prior use of muscle relaxants. The request for Lidoderm patches #60 was denied because it was recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy which was not documented. The request for Ketoprofen gel 120ml was denied because it was not currently FDA approved for a topical application and it has an extremely high incidence of photocontact dermatitis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zanaflex 4mg BID #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, Tizanidine Page(s): pages 63,66.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines state non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain (LBP). Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. They show no benefit beyond nonsteroidal anti-inflammatory drugs (NSAIDs) in pain and overall improvement. Guidelines state that Zanaflex is a centrally acting alpha 2-adrenergic agonist that is FDA approved for management of spasticity and myofascial pain. In this case, the patient has been using Zanaflex since June 2013 without evidence of overall pain improvement and functional gains. Furthermore, guidelines do not support long term use of Zanaflex. The medical necessity has not been established. Therefore, the request is not medically necessary

**Lidoderm Patches #60, Use as directed:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topicals.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine Patch) Page(s): 56-57.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines state, topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. However, further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. In this case, the patient has been prescribed Lidoderm patches since June 2013. However, there was no documentation of a trial of first-line therapy. There is no clear indication for the requested medication at this time. Therefore, the request is not medically necessary.

**Ketoprofen Gel 120ml Use as directed:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topicals.

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

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines state Ketoprofen is not recommended for topical use as there is a high incidence of photo contact dermatitis. In this case,

the patient has been prescribed Ketoprofen gel since June 2013; however, it is not recommended for topical use as stated above. Therefore, the request is not medically necessary.