

<b>Case Number:</b>	CM14-0064974		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	10/03/2011
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	04/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2014

### 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 60 year old male who was injured on 10/03/2011. The mechanism of injury was probably a cumulative trauma injury to the upper extremities, cervicothoracic and lumbar spine. Prior treatment history has included unknown completed sessions of physical therapy. Progress report dated 02/22/2013 states "the patient complained of neck pain on the right as well as in the trapezius and parascapular areas with the pain being present all of the time radiating into the right upper arm." He reported increased neck pain and upper back pain that occurs with movement. He rated his pain as a 5-6/10 at its best and an 8/10 at its worse. He did report that his pain is relieved with medications. He reported pain in all of his fingers at a level of approximately 4-5/10 and painful bone spurs. He said he was awakened by the pain every night. On exam, he had tenderness at the cervicothoracic junction. There was left-sided paracervical and trapezius muscle tenderness as well as right parascapular tenderness. Range of motion of the neck revealed flexion to 70; extension to 45; lateral bending to 40 bilaterally and rotation to 50 bilaterally. Examination of the upper extremities was essentially normal with the exception of tenderness at the right shoulder. He was able to squat to approximately 50 percent of normal. There was midline tenderness to the back from L4 to the lower sacrum. He was diagnosed with degenerative disc disease and spondylosis of the cervical spine, bilateral cubital tunnel syndrome, status postoperative bilateral ulnar nerve decompression at the elbows, bilateral carpal tunnel syndrome, and status post postoperative bilateral carpal tunnel release. The following medications were requested for the patient on 04/03/2014 including Norco 7.5/325 mg, Cymbalta 60 mg, Zanaflex 4 mg #90, Elavil 25 mg #40, Lidoderm #90 and Terocin Cream. Prior utilization review dated 04/10/2014 states the requests for Zanaflex 4mg #90, Lidoderm #90, and Terocin Cream are not certified as medical necessity had not been established.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Zanaflex 4mg #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 Tizanidine Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Zanaflex.

**Decision rationale:** The CA MTUS Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines (ODG) recommend non-sedating muscle relaxants in certain situations and for a short course of therapy. 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 and for short-term usage with duration of less than 2 weeks for treatment of acute exacerbations of low back pain. Limited, mixed-evidence does not allow for a recommendation for a chronic use. Efficacy appears to diminish over time and prolonged use of some medications in this class may lead to dependence. I concur with utilization review opinion dated 04/10/2014 that this medication is not medically necessary. The medical records do not indicate that the patient was experiencing an acute flare up of his back pain.

**Lidoderm #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain, Topical analgesics.

**Decision rationale:** Per the CA MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are recommended as an option for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Lidocaine Indication: Neuropathic pain 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). Per The Official Disability Guidelines, Lidocaine is recommended for localized pain that is consistent with neuropathic etiology 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). Review of the medical records do not support documentation of failed trials of first line therapy (tri-cyclic or SNRI Anti-Depressants or and AED such as Gabapentin or Lyrica.) Therefore, a trial of Lidocaine Patches is not medically necessary.

**Terocin Cream:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation <http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=100ceb76-8ebe-437b-a8de-37cc76ece9bb>.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines (California MTUS) indicate 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. Many agents are compounded as monotherapy or in combination for pain control including: nonsteroidal anti-inflammatory drugs (NSAIDs), opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, gamma agonists, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factors. There is little to no research to support the use of many these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis, but either not afterward or with a diminishing effect another two week period. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. It is not recommended for neuropathic pain as there is no evidence to support its use. Capsaicin: recommended only as option in patients who have not responded or are intolerant to other treatments. Per the CA MTUS Chronic Pain Medical Treatment Guidelines: Lidocaine Indication, Neuropathic pain 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). The medical necessity of this request has not been established and is not medically necessary.