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| Case Number: | CM14-0073714 | | |
| Date Assigned: | 07/16/2014 | Date of Injury: | 10/30/1994 |
| Decision Date: | 08/28/2014 | UR Denial Date: | 05/05/2014 |
| Priority: | Standard | Application Received: | 05/21/2014 |

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 Nevada. 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 records presented for review, indicate that this 68-year-old female was reportedly injured on 10/30/1994. The mechanism of injury was not listed in the records reviewed. The most recent progress note, dated 6/18/2014, indicated that there were ongoing complaints of low back pain that radiated down the right lower extremity. The physical examination demonstrated cervical spine positive tenderness to palpation of the cervical paraspinal muscles and trapezius muscles. There was limited range of motion. Upper extremity had decreased sensation in the right C6-C7 (cervical) dermatomes. Low back had positive tenderness to palpation of the lumbar paraspinal muscles with notable spasm and limited range of motion. Decreased sensation in the right L5 (lumbar) dermatome. No recent diagnostic studies are available for review. Previous treatment included home exercise regimen and medications. A request was made for Celebrex 100 mg #60, Zanaflex 2 mg #30, Lidoderm patch #60 and was denied in the pre-authorization process on 5/5/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 70.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Chronic Pain Medical Treatment: Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009), page 30 of 126 Page(s): 30 of 126.

Decision rationale: Chronic Pain Medical Treatment Guidelines support the use of Celebrex in select clinical settings of acute pain and in conditions for which non-steroidal anti-inflammatory medications (NSAIDs) are recommended when the claimant has a risk of gastrointestinal (G.I.) complications. The medical record provided clinical data to support a diagnosis of chronic pain. There was no documentation in the record of gastritis, or any other risk factor. In the absence of documentation of risk factors to identify the claimant to be at high risk, the use of this medication in the setting of chronic pain would not be supported by the guidelines. Therefore, this request is deemed not medically necessary.

Zanaflex 2mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Anti-spasmodic drugs Page(s): 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009): Anti-Spasticity/Anti-spasmodic drugs, page 66 of 127 Page(s): 66 of 127.

Decision rationale: Zanaflex (tizanidine) - Tizanidine is a centrally acting alpha2-adrenergic agonist that is Food and Drug Administration (FDA) approved for management of spasticity. It is unlabeled for use in low back pain. Muscle relaxants are only indicated as second line options for short-term treatment. This medication is being used on a chronic basis, which is against the guideline recommendations. Therefore, this medication is deemed not medically necessary.

Lidoderm patches #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009), page 56 of 127 Page(s): 56 of 127.

Decision rationale: MTUS Guidelines support the use of topical lidocaine for individuals with neuropathic pain that have failed treatment with first-line therapy including antidepressants or anti-epileptic medications. Based on the clinical documentation provided, there is no documentation of failed first-line treatments. As such, the request is considered not medically necessary.