

<b>Case Number:</b>	CM14-0075952		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	06/03/1998
<b>Decision Date:</b>	08/22/2014	<b>UR Denial Date:</b>	05/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/23/2014

### 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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 63-year-old female who reported an injury on 06/03/1998. The mechanism of injury was not provided within the medical records. The clinical note dated 07/08/2014, which is handwritten and hard to decipher, indicated diagnoses of cervical spine sprain/strain with anterolisthesis of C5 on C6 with slight degenerative joint disease, thoracic spine sprain/strain with history of protrusion from T6-7 with recent history of increased symptoms, lumbar spine sprain/strain with facet degenerative joint disease, scoliosis to the right, and severe degenerative disc disease at L2-3 with spondylosis at L4-5 with spinal cord stimulator at L1-3 with recent history of increased symptoms. The injured worker reported right shoulder pain with weakness and difficulty. On physical examination, the right shoulder was tender. The injured worker's prior treatments included diagnostic imaging and medication management. The injured worker's medications included Zanaflex, Neurontin, and Lidoderm. The provider a request for Zanaflex, Lidoderm, Neurontin, and home health care. A request for authorization was not submitted for review to include the date the treatment was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home Care Assistance 7 days a week, 24 hours a day for 3 months: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

**Decision rationale:** The request for Home care assistance 7 days a week, 24 hours a day for 3 months is not medically necessary. The CA MTUS Guidelines recommend home health services only for otherwise recommended medical treatment for patients who are homebound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. There is a lack of evidence of the injured worker being homebound or attending any type of rehabilitation service program such as physical therapy. In addition, the provider did not indicate a rationale for the request. Furthermore, homemaker services like shopping, dressing, and bathing are not included in medical treatment. Therefore, the request is not medically necessary.

**Zanaflex 4mg Qty 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 (Zanaflex) Page(s): 66.

**Decision rationale:** The request for Zanaflex 4mg #90 is not medically necessary. The California MTUS Guidelines recognize Zanaflex as a centrally acting alpha2-adrenergic agonist muscle relaxant that is FDA approved for management of spasticity unlabeled use for low back pain. There is a lack of documentation of efficacy and functional improvement with the use of this medication. In addition, the documentation did not indicate how long the injured worker had been utilizing this medication. Moreover, the documentation did not indicate a pain assessment of the injured worker. Moreover, the request did not indicate a frequency for the medication. Therefore, the request is not medically necessary.

**Neurontin 600mg Qty 180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Specific Anti-Epilepsy Drugs Page(s): 18.

**Decision rationale:** The request for Neurontin 600mg #180 is not medically necessary. The California MTUS Guidelines recognize gabapentin/Neurontin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. It was not indicated when the injured worker was prescribed this medication. In addition, there was a lack of documentation of efficacy and

functional improvement with the use of this medication. Moreover, there was a lack of a pain assessment provided on the injured worker. Additionally, the request did not indicate a frequency for this medication. Therefore, the request for Neurontin is not medically necessary.

**Lidoderm Patch 5% Qty 30:** 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, 112.

**Decision rationale:** The request for Lidoderm Patch 5% #30 is not medically necessary. The California MTUS indicates topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safe are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The California MTUS Guidelines indicate that topical lidocaine (Lidoderm) may be 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). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. It was not indicated the injured worker had tried and failed antidepressants or anticonvulsants. In addition, there was a lack of documentation of efficacy and functional improvement with the use of this medication. Moreover, the request did not indicate a frequency for this medication. Therefore, the request is not medically necessary.