

<b>Case Number:</b>	CM14-0079737		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	02/16/2007
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	05/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/30/2014

### 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 64-year-old individual was reportedly injured on February 16, 2007. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated May 5, 2014, indicated that there were ongoing complaints of right sided low back pain. It was noted that the previous facet rhizotomy reduced the pain approximately 75% however, after several weeks the pain reoccurred. The physical examination demonstrated pain over the facet joints, a decreased lumbar spine range of motion and a negative straight leg raise. Diagnostic imaging studies were not referenced. Previous treatment included facet rhizotomy (L3-L4, L4-L5, and L5-S1), physical therapy, multiple medications and pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on May 15, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm patches #3:** 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): 56,57,112 of 127.

**Decision rationale:** As outlined in the MTUS, this topical preparation is for individuals with a neuropathic pain generator. Based on the response to the facet injections, the pain generator is a nociceptive lesion that responds well to injection therapy. Therefore, when considering the parameters outlined in the MTUS and by the physical examination findings reported, there is no clear clinical indication establishing the medical necessity for the continued use of this topical preparation. As such, this request is not medically necessary.

**Tylenol No. 3 #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78,88,91 of 127.

**Decision rationale:** As outlined in the MTUS, this medication is for the management of moderate to severe breakthrough pain. The MTUS does support this medication at the lowest possible level that allows for increased functionality and decrease pain complaints. Based on the progress note reviewed, the efficacy of this medication has not been established. The only significant success made is with the facet injections. As such, when there is no increased functionality, or decreased pain complaints secondary to the oral analgesics, there is no clinical data presented supporting the medical necessity for its ongoing use. As such, this request is not medically necessary.

**Lyrica 75mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ant-epilepsy drugs (AED's).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19,99 of 127.

**Decision rationale:** As outlined in the guidelines, this medication has been documented to be effective in treating diabetic neuropathy and post-herpetic neuralgia. There is an off label use of this medication for neuropathic pain lesions and is documented in the progress notes. The pain lesion is nociceptive in nature. As such, there is no narrative presented to support the clinical position of continuing this medication. Therefore, this request is not medically necessary.

**Lunesta 3mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)Mental Illness & Stress Procedure Summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter updated August, 2014.

**Decision rationale:** As outlined in the literature (MTUS & ACOEM do not address) noted in the Official Disability Guidelines (ODG), this medication is indicated for the short-term treatment of insomnia. This treatment is less than 4 weeks. Therefore, there is no support for chronic or indefinite use of this medication. While understanding of sleep hygiene is a crucial part in a chronic pain management protocol, the limitations of the medications have to be expected. Therefore, there is insufficient data presented to support the indefinite use of this medication. As such, this request is not medically necessary.

**Tizanidine 4mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)Pain Procedure SummaryMuscle Relaxants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 63-66 of 127.

**Decision rationale:** Zanaflex (Tizanidine) is a centrally acting alpha 2-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 2nd line options for short-term treatment. It appears that this medication is being used on a chronic basis, which is not supported by MTUS treatment guidelines. Therefore, this medication is not medically necessary.

**4 Urine Drug Screens:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)Urine Drug Screens.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004): Criteria for use of opioids, page 78.

**Decision rationale:** As outlined in the ACOEM guidelines, drug screening is warranted if there are issues relative to abuse, addiction, poor pain control, or other parameters. The progress notes indicate that these issues are present. There is no data to suggest drug diversion or illicit drug use. Therefore, when noting the parameters outlined in the ACOEM guidelines and by the physical examination reported, there is no data to suggest for additional urine drug screenings completed. Therefore, this request is not medically necessary.