

<b>Case Number:</b>	CM14-0117495		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	05/14/1998
<b>Decision Date:</b>	01/29/2015	<b>UR Denial Date:</b>	07/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2014

### 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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 47-year-old man who sustained a work-related injury on May 14, 1998. Subsequently, the patient developed chronic low back and bilateral leg pain. According to a progress report dated July 1, 2014, the patient complained of low back and bilateral leg pain. He recently underwent an updated MRI of the lumbar spine that revealed multilevel degenerative disc and joint disease in addition to postsurgical changes. There was no evidence of any disc herniation causing nerve impingement. On examination, the patient demonstrated limited range of motion of the lumbar spine. He reported pain throughout range of motion testing. There was marked point tenderness to bilateral paraspinals and bilateral superior gluteal; region. Sensation was decreased in the bilateral L5 and S1 dermatomes. Achilles reflex was hypoactive bilaterally. Patella reflex was symmetric. Straight leg test was now positive. There was no evidence of hypertonicity or clonus. Distal pulses were intact. The patient was diagnosed with low back pain, lumbar disc herniation, lumbar radiculopathy, lumbosacral spondylosis, and disturbance of skin sensation. The provider requested authorization for Provigil, Zanaflex, AndroGel Pump1.62% Topical Gel, and Cymbalta.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Provigil 200 mg # 50:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers Compensation

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Modafinil. <http://reference.medscape.com/drug/provigil-modafinil-343000>.

**Decision rationale:** Provigil is a Neurostimulator used for shift work sleep disorder; narcolepsy; obstructive sleep apnea/hypopnea syndrome. There is no documentation that the patient is suffering from any of these conditions. Therefore, the request is not medically necessary.

**Zanaflex 4 mg # 120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 63-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** According to MTUS guidelines, non-sedating muscle relaxants are recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient was previously treated with Zanaflex for at least more than 4 months, which is considered a prolonged use of the drug. There is no continuous and objective documentation of the effect of the drug on patient pain, spasm and function. There is no recent documentation for recent pain exacerbation or failure of first line treatment medication. Therefore, the request for Zanaflex 4mg #120 is not medically necessary.

**AndroGel Pump 1.62% Topical Gel:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 110.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence's: AndroGel 1%. (<http://www.rxlist.com/androgel-drug/indications-dosage.htm>).

**Decision rationale:** AndroGel 1% is an androgen indicated for replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone. There is no documentation that the patient developed hypogonadism. Therefore, the prescription for Androgel pump 1.62% is not medically necessary.

**Cymbalta 60 mg Capsule DR # 30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 13.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta Page(s): 43.

**Decision rationale:** According to MTUS guidelines, there is no high quality evidence to support the use of Cymbalta for lumbar radiculopathy and radicular pain there is no documentation about the efficacy of the drug for the management of the patient pain. Cymbalta is usually used for neuropathic pain and there is no clear evidence of neuropathic pain in this case. Therefore Cymbalta is not medically necessary.