

Case Number:	CM14-0191088		
Date Assigned:	11/24/2014	Date of Injury:	10/07/1994
Decision Date:	01/09/2015	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/17/2014

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 Internal Medicine, and is licensed to practice in New York. 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 claimant is a 55 year old female who sustained an industrial injury on 10/07/1994. The mechanism of injury was not provided for review. Her diagnoses include low back pain, failed back syndrome status post L4-L5 fusion, myofascial pain, right knee pain status post TKR, and depression secondary to chronic pain. She continues to have flares of low back pain. On physical exam she has pain with lumbar range of motion. There were no neurologic abnormalities documented on exam. The treating provider has requested Zanaflex 4mg #120, and Lidoderm patch 5% # 30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines, pain chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

Decision rationale: Tizanidine (Zanaflex) is a centrally acting alpha-2-adrenergic agent FDA approved for the treatment of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and as adjunct treatment for the treatment of fibromyalgia.

Per California MTUS Guidelines muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. The claimant has no reported lumbar spasm on exam. She has been maintained on the medication for a prolonged period of time without any reported increased functional improvement. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Lidoderm 5% patch #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: There is no documentation provided necessitating use of the requested topical medication. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, γ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating the use of Lidocaine patches. Per California MTUS 2009 Guidelines Lidoderm is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an anticonvulsant medication such as Gabapentin or Lyrica. The medication is only FDA approved for post-herpetic neuralgia. There is no documentation of intolerance to other previous treatments. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.