

Case Number:	CM14-0198635		
Date Assigned:	12/08/2014	Date of Injury:	11/07/2010
Decision Date:	01/21/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/25/2014

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 Preventive Medicine and is licensed to practice in California. 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 62 years old with a reported date of injury as 01/02/1973 - 11/07/2010. The mechanism of injury was not listed in the records reviewed. According to the primary treating physician's re-evaluation and progress report dated August 19, 2011 the injured worker remains temporarily totally disabled and was awaiting authorization for recommended cervical spine surgery. The injured worker complained of persistent pain of the neck that was aggravated by repetitive motions of the neck and working at or above shoulder level. The injured worker reported having low back pain that was aggravated by bending, lifting, twisting, pushing, pulling, sitting, standing and walking. Physical examination of the cervical spine revealed tenderness at the paravertebral muscles and upper trapezial muscles with spasm. Axial loading compression test and Spurling's maneuver were positive. There was pain and restricted cervical range of motion with dysesthesia noted at C5 and C6 dermatomes. Physical examination of bilateral wrists revealed pain with terminal flexion, positive Tinel's and Phalen's signs. Additionally, tenderness at the lumbar paravertebral muscles, pain with terminal motion, and limited range of motion with positive seated nerve root test was noted. No medication list was provided for this review. Diagnoses were listed as cervical discopathy, lumbar discopathy and carpal tunnel syndrome/double crush syndrome. Documentation of previous treatments, diagnostic study images or reports was not provided for this review. The prescribed plan of care included; Tizanidine Hydrochloride 4 mg; dispense 120 tablets one tablet to be taken every 8 hours as needed for pain. Gabapentin 600 mg, dispense 120 tablets one tablet to be taken three times a day for neuropathic pain. Medrox Ointment, dispense 120 for temporary relief of minor aches or muscle pain. The physician noted that these medications provided the injured worker the ability to perform activities of daily living on a daily basis. A request for authorization form, dated 10/15/2014 was submitted for the retrospective approval of the above medications for the service

date of 08/19/2011. A utilization review determination dated 10/29/2014 denied the request for retrospective Tizanidine Hydrochloride 4 mg; dispense 120 tablets, Gabapentin 600 mg, dispense 120 tablets and .Medrox Ointment, dispense 120 for the service date of 08/19/2011 due to no evidence of objective functional benefit with medication use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medrox ointment # 120 DOS 8/19/11: 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): 111-113.

Decision rationale: Medrox cream is a compounded medication that includes 0.0375% Capsaicin, 20% Menthol, and 5% Methyl Salicylate. MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that many agents are compounded as monotherapy or in combination for pain control; that Ketoprofen, Lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of cervical discopathy, lumbar discopathy, and carpal tunnel syndrome/double crush syndrome. However, Medrox cream contains at least one drug (capsaicin in a 0.0375% formulation) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Medrox ointment # 120 DOS 8/19/11 is not medically necessary.

Tizandine 4 mg # 120 DOS 8/19/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs (Tizanidine (Zanaflex)) Page(s): 66.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of spasticity, as criteria necessary to support the medical necessity of Zanaflex. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of cervical discopathy, lumbar discopathy, and carpal tunnel syndrome/double crush syndrome. In addition, there is documentation of Tizanidine used as a second line option. However, there is no documentation of spasticity. In addition, given the requested Tizanidine #120, there is no documentation of short-term (less than

two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Therefore, based on guidelines and a review of the evidence, the request for Tizanidine 4 mg # 120 DOS 8/19/11 is not medically necessary.

Gabapentin 600 mg # 120, DOS 8/19/11: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (gabapentin). Within the medical information available for review, there is documentation of diagnoses of cervical discopathy, lumbar discopathy, and carpal tunnel syndrome/double crush syndrome. In addition, there is documentation of neuropathic pain. Therefore, based on guidelines and a review of the evidence, the retrospective request for Gabapentin 600 mg # 120, DOS 8/19/11 is medically necessary.