

<b>Case Number:</b>	CM15-0131941		
<b>Date Assigned:</b>	07/20/2015	<b>Date of Injury:</b>	06/11/2001
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	06/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/08/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Emergency Medicine

### 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 60 year old female, who sustained an industrial injury on June 11, 2001. The injured worker's initial complaints and diagnoses are not included in the provided documentation. The injured worker was diagnosed as having sciatica, disorders of sacrum, chronic pain (not elsewhere classified), and lumbar disc myelopathy with myelopathy. Diagnostic studies to date have included: On September 27, 2006, electromyography revealed no abnormal findings. On August 21, 2012, an MRI of the lumbar revealed a 4-5 millimeter broad-based central disc protrusion at lumbar 3-4 with mild to moderate central spinal canal stenosis, moderate narrowing of the caudal margin of the neuroforamen bilaterally, slight impression on the exiting lumbar 3 nerve roots in the neural foramen bilaterally, and bilateral facet arthropathy. At lumbar 4-5, there was a 3-4 millimeter broad-based central disc protrusion mild central spinal canal stenosis, a right paracentral annular tear, severe right neural foraminal narrowing, mild left neural foraminal narrowing, and bilateral facet arthropathy. Surgeries: a percutaneous discectomy. Treatment to date has included physical therapy, chiropractic therapy, acupuncture, lumbar epidural steroid injections, a transcutaneous electrical nerve stimulation (TENS) unit, and medications including opioid analgesic, topical analgesic, anti-epilepsy, and muscle relaxant. There were no noted previous injuries or dates of injury. Comorbid diagnoses included history of myocardial infarction, hypothyroidism, hyperlipidemia, hypertension, and cardiovascular angioplasty. On May 12, 2015, the injured worker complained of chronic lower back pain radiating into her left lower extremity, which was unchanged since the prior visit. Her oral pain medications improve her pain by 80%. Her anti-epilepsy medications help to decrease her

neuropathic pain and help her sleep at night. She uses Flexeril for muscle spasms and Lidoderm patches. The physical exam revealed an antalgic gait and normal muscle tone without atrophy of the bilateral upper and lower extremities. Work status: permanent and stationary. The treatment plan includes continuing the Lidoderm 5% patch and Flexeril 10mg tablet.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Flexeril 10mg tablet, 1 by mouth twice a day, #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-64.

**Decision rationale:** The request is for Flexeril, or Cyclobenzaprine, which is an antispasmodic that is used to decrease muscle spasm in conditions such as low back pain, although it appears that these medications are often used for the treatment of musculoskeletal conditions whether spasm is present or not. The mechanism of action for most of these agents is not known. Non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases, they show no benefit beyond non-steroidal anti-inflammatory drugs in pain and overall improvement. Also there is no additional benefit shown in combination with non-steroidal anti-inflammatory drugs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine is not recommended to be used for longer than 2-3 weeks. The injured worker has been prescribed cyclobenzaprine for far longer than recommended by the MTUS, and is unlikely to be of ongoing medical benefit. Therefore, the request as written is not medically necessary.

**Lidoderm 5% patch 700mg/patch, apply 3 patches daily 12 hours on, 12 hours off, #90 with 5 refills: 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 is for Lidoderm 5%, which is a topical compound applied to the skin. Topical analgesics are recommended as an option in specific situations. Largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants

have failed. Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Lidocaine 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 anti-epileptic drug such as Gabapentin or Lyrica). Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Lidoderm is not recommended for non-neuropathic pain. There is only one trial that tested 4% Lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. The injured worker previously had a normal electromyography study. The documentation does not clearly describe neuropathic pain that was unable to be treated by first line agents. The request as written is therefore not medically necessary.