MAXIMUS Federal Services

Case Number:	CM15-0033724		
Date Assigned:	04/02/2015	Date of Injury:	01/07/2012
Decision Date:	05/01/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/23/2015

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: Physical Medicine & Rehabilitation, Pain Management

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 51-year-old male who sustained an industrial injury on January 7, 2012. The injured worker was diagnosed with sprain right shoulder/arm, right rotator cuff syndrome, myalgia, and myositis. The injured worker had a cervical spine magnetic resonance imaging (MRI) on August 13, 2014. According to the primary treating physician's progress, report on December 30, 2014 the injured worker continues to experience right shoulder pain. Examination of the cervical spine demonstrated mild tenderness with right scalene tightness with trigger points. Myofascial test noted trigger points with taut bands in the right levator scapulae. Examination of the right upper extremity demonstrated a mild decrease in sensation, equal and symmetrical deep tendon reflexes, negative Spurling's and positive impingement test on the right. Electromyography (EMG)/Nerve Conduction Velocity (NCV) studies showed no active radiculopathy according to this report. Current medications are listed as Lidoderm Patches and Tizanidine for spasms and are requested for authorization by the physician. A progress report dated March 16, 2015 indicates that the patient has had "prior treatment with tizanidine and Lidoderm patches, trigger point injections and physical therapy with minimal relief of symptoms." The treatment plan recommends the use of gabapentin and an epidural injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 4 MG/Tab; 1 Tab By Mouth Q As Needed #30 with 3 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

Decision rationale: Regarding the request for tizanidine (Zanaflex), Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that tizanidine specifically is FDA approved for management of spasticity; unlabeled use for low back pain. Guidelines recommend LFT monitoring at baseline, 1, 3, and 6 months. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the tizanidine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested tizanidine (Zanaflex), is not medically necessary.

Lidoderm 5 Percent (700MG/Patch), Apply to Pain Area Every 12 Hours #30 with 3 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 112 of 127.

Decision rationale: Regarding request for topical lidoderm, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Additionally, there is no documentation of analgesic effect or objective functional improvement as a result of the currently prescribed lidoderm. Finally, there is no documentation of localized peripheral pain as recommended by guidelines. As such, the currently requested lidoderm is not medically necessary.