

<b>Case Number:</b>	CM15-0035773		
<b>Date Assigned:</b>	03/04/2015	<b>Date of Injury:</b>	04/28/2006
<b>Decision Date:</b>	04/15/2015	<b>UR Denial Date:</b>	01/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2015

### 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

### 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 58 year old female injured worker suffered an industrial injury on 4/28/2006. The diagnoses were cervical and lumbar radiculitis, headaches, depression, insomnia, chronic pain, fibromyalgia, spinal cord stimulator, and chronic regional pain syndrome. The diagnostic studies were computerized tomography of the cervical spine, thoracic spine and lumbosacral spine, magnetic resonance imaging of the right shoulder, and electromyography. The treatments were medications and acupuncture. The treating provider reported neck pain, low back pain, bilateral upper extremity pain and left lower extremity pain rated as 4 to 5/10 with medications and 6 to 7/10 without medications that is worsening. There was tenderness to the lumbar spine, decreased range of motion limited by pain which increased with motion. There was tenderness to both hands and decreased range of motion due to pain. Also noted was atrophy of the hands. The Utilization Review Determination on 1/28/2015 non-certified: 1. Tizanidine 4mg #60, MTUS. 2. Enovarx-Ibuprofen 10% kit #1, MTUS.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tizanidine 4mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

**Decision rationale:** The patient presents with pain and weakness in her neck, lower back and upper/ lower extremities. The request is for TIZANIDINE 4MG #60. Per 01/28/15 progress report, the patient is currently taking Duloxetine DR, Lidoderm patch, Lyrica, Restone, Tizanidine and Vitamin D. The patient is currently not working. MTUS guidelines page 64-66 recommend muscle relaxants as a short course of therapy. Page 66 specifically discusses Tizanidine and supports it for low back pain, myofascial and fibromyalgia pain. In this case, the patient has been utilizing Tizanidine since at least 10/03/14. The patient does present with low back pain, which this medication indicates for. However, there is no discussion as to how this medication has been helpful with pain and function. MTUS page 60 states that when medication is used for chronic pain, recording of pain and function needs to be provided. Therefore, the request of Tizanidine IS NOT medically necessary.

**Enovarx-Ibuprofen 10% kit #1:** 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 analgesic Page(s): 111-113.

**Decision rationale:** The patient presents with pain and weakness in her neck, lower back and upper/ lower extremities. The request is for ENOVARX-IBUPROFEN 10% KIT #1. Per 01/28/15 progress report, the patient is currently taking Duloxetine DR, Lidoderm patch, Lyrica, Restone, Tizanidine and Vitamin D. The patient is currently not working. MTUS Guidelines page 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety". It further states that NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use 4-12 weeks." In this case, none of the reports mention Enovarx-Ibuprofen kit except the request. The patient presents with multiple pain issues including elbow and knee arthritic pains. The treater does not discuss how this medication is to be used and why topical is being prescribed. The treater does not explain what other treatments have failed. The request IS NOT medically necessary.