

<b>Case Number:</b>	CM15-0039659		
<b>Date Assigned:</b>	03/12/2015	<b>Date of Injury:</b>	11/16/2012
<b>Decision Date:</b>	04/16/2015	<b>UR Denial Date:</b>	02/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/02/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 37 year old male, who sustained an industrial injury on 11/16/2012. On provider visit dated 12/15/2014 the injured worker has reported low back pain that radiates down left lower extremity. Examination was noted as no significant change. The diagnoses have included low back pain radiating to left lower extremity status post left L4-L5 laminectomy and discectomy. Treatment to date has included epidural steroid injection, MRI and medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trazodone 50mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trazodone. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Schwartz, T., et al. (2004). ""A comparison of the effectiveness of two hypnotic agents for the treatment of insomnia"." Int J Psychiatr Nurs Res 10(1): 1146-1150.

**Decision rationale:** There is no clear evidence that the patient was diagnosed with major depression requiring Trazodone. There is no formal psychiatric evaluation documenting the diagnosis of depression requiring treatment with Trazodone. In addition, there is no documentation of failure of first line treatments for insomnia and depression. Therefore, the request for Trazodone 50mg #30 is not medically necessary.

**Tizanidine 4mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex).

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

**Decision rationale:** According to MTUS guidelines, a non sedating muscle relaxants is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient was previously treated with Tizanidine for at least 12 months, which is considered a prolonged use of the drug. There is no continuous and objective documentation of the effect of the drug on patient pain, spasm and function. There is no recent documentation for recent pain exacerbation or failure of first line treatment medication. Therefore, the request for Tizanidine 4mg #30 is not medically necessary.

**Biofreeze one tube:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back, Lumbar & Thoracic (Acute & Chronic).

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

**Decision rationale:** According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. According to ODG guidelines, “Biofreeze is recommended as an optional form of cryotherapy for acute pain. Biofreeze is a nonprescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. Whereas ice packs only work for a limited period of time, Biofreeze can last much longer before reapplication. This randomized controlled study designed to determine the pain-relieving effect of Biofreeze on acute low back pain concluded that significant pain reduction was found after each week of treatment in the experimental group.” ([http://www.worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm](http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm)). There is no recent

documentation of failure or intolerance of oral first line drugs for pain management. In addition, there is no evidence of acute pain or flare-ups. Therefore, the prescription of Biofreeze Gel, is not medically necessary.