

Case Number:	CM15-0040391		
Date Assigned:	03/10/2015	Date of Injury:	02/03/2013
Decision Date:	05/04/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	03/03/2015

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 injured worker is a 41 year old female, who sustained an industrial injury on 2/3/2013. She reported injuring her low back and developing radicular pain in her right leg with numbness and tingling. Diagnoses have included lumbar post-laminectomy syndrome, lumbosacral neuritis/radiculitis and myofascial pain syndrome. Treatment to date has included physical therapy, chiropractic manipulation, acupuncture, yoga, rest and medication. According to the progress report dated 1/9/2015, the injured worker complained of low back pain, right leg pain and right knee pain. The pain was rated 8/10 on the visual analog scale (VAS). Exam of the lumbar spine revealed reduced range of motion with pain. There was altered sensation of the right L5 and S1 dermatome, as well as reduced motor strength in the right leg. Medications were refilled. The request for authorization dated 1/27/2015 included a compound cream, Norco and Zanaflex.

IMR ISSUES, DECISIONS AND RATIONALES

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

CMPD - Diclofenac/Gabapentin/Baclofen/Cyclobenzaprine/Bupivacaine Day Supply 30 Qty 240 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 Topical analgesic Page(s): 111-113.

Decision rationale: The patient was injured on 02/03/13 and presents with low back pain, right leg pain, and right knee pain. The request is for CMPD-DICLOFENAC/ GABAPENTIN/ CYCLOBENZAPRINE/ BUPIVACAINE DAY SUPPLY 30 QTY 240 WITH 3 REFILLS. The RFA is dated 01/27/15 and the patient's work status is not provided. MTUS page 111 of the chronic pain section states the following regarding topical analgesics: "Largely experimental in use with few randomized controlled trials to determine efficacy or safety." There is little to no research to support the use of many of these agents. Regarding topical NSAIDs, page 111-113 states, "Indications: 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). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Gabapentin: Not recommended. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product. Cyclobenzaprine is a muscle relaxant and is not supported for any topical formulation. The patient has a reduced lumbar spine range of motion with pain. There was altered sensation of the right L5 and S1 dermatome, as well as reduced motor strength in the right leg. In this case, the patient does not present with osteoarthritis and tendinitis as required for topical NSAIDs by MTUS Guidelines. Furthermore, MTUS Guidelines state that, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." Cyclobenzaprine is a muscle relaxant and is not supported for any topical formulation. Per MTUS, gabapentin is not recommended in any topical formulation either. Therefore, the entire compounded cream is not supported. The requested topical compound IS NOT medically necessary.

Norco 10/325 MG #120 with 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: The patient was injured on 02/03/13 and presents with low back pain, right leg pain, and right knee pain. The request is for NORCO 10/325 MG #120 WITH 2 REFILLS. The RFA is dated 01/27/15 and the patient's work status is not provided. For chronic opioid use in general, MTUS guidelines pages 88 and 89, state, "The patient should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS, page 78, also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as 'pain assessment' or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, times it takes for medication to work, and duration of pain relief. MTUS, page 98, also continues to state that the maximum dose for hydrocodone is 60 mg per day. In this case, none

of the 4 A's are addressed as required by MTUS guidelines. The treater does not provide any before-and-after medication pain scales. There are no examples of ADLs, which demonstrate medication efficacy, nor are there any discussions provided on adverse behavior/side effects. There are no pain management issues discussed such as CURES report, pain contract, etc. No outcome measures are provided either as required by MTUS guidelines. The treater provided a urine drug screen from 08/11/14; however, the results of this urine drug screen are unclear. The treating physician does not provide proper documentation that is required by MTUS guidelines for continued opioid use. Therefore, the requested Norco IS NOT medically necessary.

Zanaflex 4 MG #90 with 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants; Zanaflex (Tizanidine) Medications for chronic pain Page(s): 66, 60.

Decision rationale: The patient was injured on 02/03/13 and presents with low back pain, right leg pain, and right knee pain. The request is for ZANAFLEX 4 MG #90 WITH 2 REFILLS. The RFA is dated 01/27/15 and the patient's work status is not provided. MTUS Guidelines page 66 allows for the use of Zanaflex (Tizanidine) for low back pain, myofascial pain, and fibromyalgia. MTUS page 60 requires documentation of pain assessment and functional changes when medications are used for chronic pain. The patient has a reduced lumbar spine range of motion with pain. There was altered sensation of the right L5 and S1 dermatome, as well as reduced motor strength in the right leg. The treater does not provide any discussion regarding the efficacy of Zanaflex. There is no discussion as to how this medication has been helpful with pain and function. Page 60 of MTUS states that when medications are used for chronic pain, recording of pain and function needs to be provided. The requested Tizanidine IS NOT medically necessary.