

Case Number:	CM14-0175770		
Date Assigned:	10/28/2014	Date of Injury:	10/15/2012
Decision Date:	12/24/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/23/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant is a 36 yo male who sustained an industrial injury on 10/15/2012. The mechanism of injury occurred when he strained his lower back while working on a cooling tower. His diagnoses are low back pain, post laminectomy syndrome, spinal/lumbar degenerative disc disease- status post lumbar microdiscectomy, and sleep disturbance. He continues to complain of low back pain with radiation down the left leg. On physical examination the gait is antalgic and wide based. The lumbar range of motion is restricted with flexion limited to 60 degrees, limited by pain, and extension limited by 10 degrees. There is tenderness of the lumbar paravertebral muscles and the claimant cannot walk on heel and cannot walk on toes. Straight leg raising test is positive on the left side sitting at 45 degrees. Ankle jerk is 1/4 on the right side and 0/4 on the left side. Motor testing is limited by pain. The light touch sensation is decreased over the lateral foot, medial foot and the lateral calf on the left side. Treatment in addition to surgery has included medical therapy with narcotics, muscle relaxants, and topical medications, physical therapy and a TENS unit. The treating provider has requested Medrol 4mg Dosepak, Trazadone 50mg #60, Lidoderm patch 5% #30, and Zanaflex 4mg # 60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective usage of Medrol 4 mg Dosepak: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back

Decision rationale: Per Official Disability Guidelines (ODG), corticosteroids are indicated for the treatment of acute radicular pain. The claimant has chronic low back pain and per the documentation there is no indication of an acute flare requiring steroid therapy. He is maintained on medications for the treatment of his chronic pain condition. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Prospective usage of Trazodone 50 mg, #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-17.

Decision rationale: There is documentation provided indicating the patient has sleep issues related to the work injury. Trazodone is indicated for the treatment of sleep disorders including insomnia and depression. The medication has anxiolytic and sleep-inducing effects. Given the effectiveness of the medication, medical necessity has been established. The requested treatment is medically necessary.

Lidoderm 5% patch #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: There is no documentation provided necessitating use of the requested topical medication. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, gamma agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating the use of Lidocaine patches. Per California MTUS 2009 Guidelines Lidoderm 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 anticonvulsant medication such as gabapentin or Lyrica). The

medication is only FDA approved for post-herpetic neuralgia. There is no documentation of intolerance to other previous treatments. Medical necessity for the requested topical medications has not been established. The requested treatments are not medically necessary.

Zanaflex 4 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

Decision rationale: Tizanidine (Zanaflex) is a centrally acting alpha-2-adrenergic agent FDA approved for the treatment of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and as adjunct treatment for the treatment of fibromyalgia. Per California MTUS Guidelines muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. The claimant has no reported cervical or lumbar spasm on exam . Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.