

<b>Case Number:</b>	CM15-0095709		
<b>Date Assigned:</b>	05/22/2015	<b>Date of Injury:</b>	05/11/2006
<b>Decision Date:</b>	06/24/2015	<b>UR Denial Date:</b>	05/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/18/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 50-year-old male, who sustained an industrial injury on May 11, 2006, incurring back injuries, after being hit in the right shoulder by a wall, knocked down and trapped between the cement floor and wall. He was diagnosed with cervical disc disease with herniation with nerve compression, cervical spondylosis and bilateral frozen shoulder. Treatment included surgical interventions, exercise, heat, ice, rest, physical therapy, neuropathic medications, antidepressants, proton pump inhibitor, pain medications and transcutaneous electrical stimulation unit. Currently, the injured worker complained of persistent upper back, buttocks, legs, neck, thighs and shoulder pain with decreased range of motion. Symptoms were aggravated by ascending stairs, changing positions and daily activities. The treatment plan that was requested for authorization included physical therapy and prescriptions for Robaxin and Lidoderm Patches.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy (Includes massage) Qty: 8.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine, Physical medicine guidelines Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

**Decision rationale:** Physical therapy (Includes massage) Qty: 8.00 is not medically per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS recommends up to 10 visits for this condition. The documentation is not clear on how many prior PT sessions the patient has had; why he is unable to perform an independent home exercise program; and the evidence of functional improvement from prior lumbar PT. The request for physical therapy is not medically necessary.

**Robaxin 500mg Qty: 180.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64-66.

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

**Decision rationale:** Robaxin 500mg Qty: 180.00 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. The documentation indicates that the patient has been on Robaxin without functional improvement. The MTUS guidelines recommendation that this is a second line option for short term treatment of acute exacerbations of pain. The documentation indicates that the patient has chronic pain (not an acute exacerbation). This medication is not indicated long term. The documentation does not support the medical necessity of continued Robaxin use and therefore this medication is not medically necessary.

**Lidoderm patches Qty: 15.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch) - Topical analgesics Page(s): 56-57, 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56.

**Decision rationale:** Lidoderm patches Qty: 15.00 are not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines The guidelines state that topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. The documentation does not indicate failure of first line therapy for peripheral pain. The documentation does not indicate a diagnosis of post herpetic neuralgia. The patient has not had improvement in function on prior Lidoderm. For these reasons, the request for Lidoderm Patches is not medically necessary.

