

Case Number:	CM13-0007400		
Date Assigned:	12/11/2013	Date of Injury:	04/22/2008
Decision Date:	03/10/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	08/08/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California, Maryland, Florida, and Washington DC. 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 physician 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:

According to medical records dated 10/05/09 from Orthopedic AME [REDACTED]. Patient is a 56 years old female was employed at the [REDACTED]. She has worked there two years. On 4/22/08, she tripped on a curled door mat in the office behind the front desk. She fell to the ground hands first. She held herself up and spun around and twisted. She developed low back and right hip pain. She reported the injury. Two days later, she reported it again and was sent to [REDACTED] who obtained x-rays and an MRI, which showed moderate to severe foraminal narrowing on the left at L4-5. She had two epidurals. She had physical therapy and TPI. She has pain in the spine, right hip and cannot sleep on her back. She had a MVA in 2005 with no injuries. In 1995, she had a low back injury when a pallet fell on her back and recovered completely. She has difficulty with ADLs, stopping and pinching. Sex is painful. Her Epworth scale is 0. She is a front office manager for the [REDACTED]. She worked at [REDACTED] as a manager and at [REDACTED] as a salesperson. She sits two hours a day, stands 5 hours a day and walks 1 hour a day. Diagnosis bulging lumbar disc with degeneration and radiculopathy. Causation of the low back and right hip are to the fall. She does not have any evidence of a left leg injury or internal injuries from this accident. She needs referral to a psychologist to evaluate the sleep and sexual dysfunction. She is MMI. She is limited to no lifting more than 20 pounds and no repetitive bending and twisting. She is ORE III She is apportioned 90% to the 4/22/08 injury and 10% to her previous 1995 low back injury. She has future medical of NSIADs, PT, daily exercise program, muscle relaxants, occasional trigger point injections and epidurals and possible surgery. 3/18/11 Supplemental Report, [REDACTED] dealing with self-procured home health services. 6/23/10, EMG/NCV [REDACTED], mild acute L5 radiculopathy. 12/2/10, [REDACTED] PTP, notes that she has been paying for her own

home healthcare. 1/4/11, [REDACTED] indicates that he does not believe it is medically necessary to have a home health care provider. The diagnoses are bulging lumbar disc, right sciatica, and sleep disorder associated with #1 and #2. She should be provided home health care benefits for two weeks. She has a 13% WPI. Apportionment is 90% to the industrial injury and 10% to non-industrial. 5/5/11 Lumbar MRI, [REDACTED], requested by [REDACTED]. L1-2 and L2-3 normal. L3-4 2.5 mm left foraminal disc bulge with mild to moderate left neural foraminal stenosis. L4-5 disc desiccation and a 2.5 mm disc bulge with moderate bilateral foraminal stenosis. L5-S1 moderate facet hypertrophy and a 2.5 mm disc bulge with severe left and moderate to severe right foraminal stenosis with severe bilateral lateral recess stenosis and mild central stenosis with an AP diameter of 9 mm. In 6/26/13 progress report states that patient complains of back and neck pain which radiate even down to the right great toe. Much of her pain is due to the back and leg. Patient is concerned about a rash, which she thinks is related to Opana. The treating physician has changed Opana to Tapentadol. Patient says that voltaren gel provides good relief for her right knee. The patient is able to do laundry and cook but is unable to perform these activities without the medications. The pain is rated at 10/10 without medications and 7/10 with medications. CURES and UDS reporting are in place with no anomaly. The review of record shows EMG/NCV impression of mild acute L5 radiculopathy (3/16/13); MRI shows stenosis in the lower lumbar region (1/9/12). There was discussion that the patient is not a surgical candidate. Physical exam showed paracervical trigger points, back was tender to palpation with guarding but no spasms. Lumbar ROM was minimally decreased and painful on flexion and extension. SLR was positive on the right. Lower extremity streng

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizandine (Zanaflex) 4mg oral cap # 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC-Pain (Chronic)(Updated 11/14/2014) Muscle Relaxants-Zanaflex® (tizanidine):Zanaflex® is a muscle relaxant.

Decision rationale: With respect to Zanaflex (a non-sedating muscle relaxant), the guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term (less than two weeks) treatment of acute LBP and for short-term treatment of acute exacerbations in patients with chronic LBP. There is no indication that the first line recommended medication has failed in controlling the patient pain symptoms. .Beside being unlabelled for low back pain treatment, there is no documentation of this patients renal or hepatic function test result in the record reviewed prior to prescription of this medication. This medication is related to clonidine and should not be discontinued abruptly. Weaning should occur gradually, particularly in patients that have had prolonged use. This reviewer consider the prescription of Tizandine (Zanaflex) 4mg oral cap # 90 is not medically necessary.

Duloxetine (Cymbalta) 30mg #90, 3 times per day: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta Page(s): 15-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC-Pain (Chronic)(Updated 11/14/2013)-Duloxetine (Cymbalta®).

Decision rationale: With respect to Cymbalta (Duloxetine), CA-MTUS guidelines states that Duloxetine is recommended as an option a first-line option for diabetic neuropathy. No high quality evidence is reported to support the use of duloxetine for lumbar radiculopathy. In patients diagnosed with fibromyalgia, and the ODG guidelines recommended that treatment of fibromyalgia with duloxetine should be initiated at 30 mg/day for 1 week and then up titrated to the recommended 60-mg dose. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Multiple dosage of Cymbalta have been prescribed, and the rationale was not included in the documentation provided. Based on the above guideline recommendation, the request for Duloxetine (Cymbalta) 30mg #90, 3 times per day, is not medically necessary.