

<b>Case Number:</b>	CM13-0028401		
<b>Date Assigned:</b>	11/27/2013	<b>Date of Injury:</b>	04/02/2013
<b>Decision Date:</b>	01/27/2014	<b>UR Denial Date:</b>	09/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2013

### 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 Physical Medicine and Rehabilitation, and is licensed to practice in California. 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:

The underlying date of injury in this case is 04/02/2013. Treating diagnoses include C3-C4 uncovertebral hypertrophy as well as a C3-C4 broad-based osteophyte, C3-C4 mild to moderate neural foraminal narrowing, status post C7 disc replacement, and lumbago. On 07/11/2013, the treating physician noted that the patient reported constant, aching pain in the arm and numbness/tingling in the hands/arms with pulling in the right biceps. The patient had decreased motion in the cervical and lumbar spine and right shoulder. The patient was felt to be improving with a cervical radiculopathy and thoracic and lumbar sprain and history of a cervical disc replacement. The treating physician recommended an MRI of the cervical and thoracic spine as well as an additional course of physiotherapy and chiropractic and continued medications. An initial physician review in this case noted that an MRI of the lumbar spine was not indicated without red flags to support a rationale for this request including no documentation of radicular pain or objective findings of radiculopathy. That review noted that tramadol would be noncertified given that there was no indication that the patient was taking antiinflammatory medications which would be the first-line treatment. This review recommended partial certification of tizanidine, recommending documentation of functional improvement and noting that the guidelines support the use of first-line drugs including NSAIDS or acetaminophen for initial continued treatment of pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the lumbar spine with contrast:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** ACOEM Guidelines, Chapter 12 Low Back, page 309, recommends MRI imaging, "when cauda equina, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative." The medical records do not document such red flags. The rationale or indication for the requested MRI is not apparent. This request is not medically necessary.

**Tramadol 50mg #360:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram, Ultram ER; generic available in immediate releas.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines Section on Tramadol, page 113, states, "Not recommended as a first-line oral analgesic." The medical records at this time do not provide an alternate rationale to support an indication for this treatment. This request is not medically necessary.

**Tizanidine 4mg #180:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex, generic available), Page(s): 66.

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines Section on Muscle Relaxants, page 66, states regarding tizanidine, "One study demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first-line option to treat myofascial pain. ..May also provide benefit as an adjunct treatment for fibromyalgia...Unlabeled use for back pain... Eight studies have demonstrated efficacy for low back pain." The guidelines, therefore, do support this medication as a first-line option for low back pain. In contrast to the prior review, the records do not require that the patient first try other classes of medications. In the current medical situation, the guidelines do support this request. This requested treatment is medically necessary.