

<b>Case Number:</b>	CM13-0042917		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	02/09/2003
<b>Decision Date:</b>	04/24/2014	<b>UR Denial Date:</b>	10/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2013

### 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 Physical Medicine and Rehabilitation, and is licensed to practice in Texas. 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 patient is a 61-year-old female who reported an injury on 02/09/2003. The mechanism of injury was not provided in the medical records. The patient was diagnosed with cervical disc displacement. Physical examination revealed the lumbar paraspinals are tender. Spasm and guarding are present. The patient can flex to 50 degrees and extend to 20 degrees, with a limited range of motion due to pain. Past medical history included arthroscopy of the left knee.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TIZANIDINE 4MG #120:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TIZANIDINE (ZANAFLEX®), Page(s): 66.

**Decision rationale:** According to the California MTUS Guidelines, tizanidine is a centrally-acting alpha 2-adrenergic agonist that is FDA-approved for management of spasticity; unlabeled use for low back pain. 8 studies have demonstrated efficacy for low back pain. 1 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. It may also

provide benefit as an adjunct treatment for fibromyalgia. The documentation submitted for review revealed spasm upon physical examination. Therefore, the request for tizanidine 4 mg #120 is certified.

**TRAMADOL 50MG #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 78.

**Decision rationale:** According to the California MTUS Guidelines, the ongoing management of patients taking opioid medications should include detailed documentation of pain relief, functional status, and the 4 A's for ongoing monitoring, which include analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The most recent clinical note submitted failed to provide evidence of increased function with the use of opioids, and whether there had been reported adverse effects or aberrant drug-taking behaviors. In the absence of detailed documentation, as required by the guidelines for the ongoing use of opioid medications, the request for tramadol 50 mg #90 is non-certified.

**COSAMIN DS 500-400 #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines GLUCOSAMINE AND CHONDROITIN SULFATE Page(s): 50.

**Decision rationale:** According to the California MTUS Guidelines, glucosamine is recommended as an option, given its low risk in patients with moderate arthritis pain, especially for knee osteoarthritis. Studies have demonstrated a highly significant efficacy for crystalline, glucosamine sulfate on all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment. The documentation submitted for review indicates the patient's left knee was better following the arthroscopy, which she underwent in 07/2012. As the guidelines state the requested medication is recommended as an option, given its low risk, the documentation submitted for review fails to provide evidence of necessity or documented functional improvement to warrant the need of the requested medication. Therefore, the request is not supported. Given the above, the request for glucosamine DS 500-400 #90 is non-certified.