

Case Number:	CM14-0112143		
Date Assigned:	08/01/2014	Date of Injury:	02/22/2007
Decision Date:	10/30/2014	UR Denial Date:	07/07/2014
Priority:	Standard	Application Received:	07/17/2014

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 Anesthesiology, has a subspecialty in Pain Medicine, and is licensed to practice in Florida. 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 injured worker is a 47-year-old female who reported an injury on 02/22/2007 due to an unknown mechanism. Diagnoses were left sacroiliac joint pain, left piriformis syndrome, and left neck and shoulder pain. Physical examination on 06/26/2014 revealed complaints of left lower back and hip pain. The injured worker had a sacroiliac joint injection which started to wear off. There were complaints of left sided neck and shoulder pain. Medications were ibuprofen, tramadol, tizanidine, and topical Flector patches. It was reported that with medications and injections, the injured worker was able to work full time and maintain mobility and function. Examination for the cervical spine revealed tenderness on the left cervical facet joints and paracervical muscles. Lumbar range of motion revealed stiffness. There was a positive pelvic tilt and right hip higher than the left. There was tenderness over the left SI joint and trochanter. FABERE's was positive on the left. Straight leg raise was negative. Sensory examination was normal in the upper and lower extremities. Motor strength was 5/5 in the upper and lower extremities. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flector Patches 1.3% #30: Upheld

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

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

Decision rationale: The decision for Flector patches 1.3% quantity 30 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The guidelines indicate that topical NSAIDs have been shown in meta analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward or with a diminishing effect over another 2 week period. The indications are for the use of topical NSAIDs or osteoarthritis and tendinitis of the knee and other joints that can be treated topically. They are recommended for short term use of 4 to 12 weeks. There is little evidence indicating effectiveness for treatment of osteoarthritis of the spine, hip, or shoulder. The request does not indicate a frequency for the medication. The efficacy of this medication was not reported. The request does not indicate where the patch is to be placed on the injured worker. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.

Ibuprofen 600mg 1 Tab three times per day with meals quantity 90.: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

Decision rationale: The decision for ibuprofen 600 mg 1 tab 3 times per day with meals #90 is medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDs are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The injured worker did report functional improvement from taking this medication. The pain score for the injured worker did decrease with taking this medication. The clinical documentation submitted for review does provide evidence that the injured worker is getting functional improvement and an objective decrease in pain. Therefore, this request is medically necessary.

Tizanidine 4mg 1 tablet every 6 hour as needed quantity:120: Upheld

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

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

Decision rationale: The decision for Tizanidine 4 mg 1 tablet every 6 hours as needed, quantity 120, is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend Tizanidine (Zanaflex) as a non-sedating muscle relaxant with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. The clinical information submitted for review does provide evidence that the injured worker has been on this medication since 01/2014. This medication as per the medical guidelines is recommended as a short term option treatment for the acute exacerbations. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Therefore, this request is not medically necessary.

Tramadol 50mg 1 tablet every 4-6 hours as needed (6/Day) quantity 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol.

Decision rationale: The decision for tramadol 50 mg 1 tablet every 4 to 6 hours as needed (6/day) #90 is not medically necessary. The California Medical Treatment Utilization Schedule states central analgesic drugs such as tramadol (Ultram) are reported to be effective in managing neuropathic pain, and it is not recommended as a first line oral analgesic. The medical guidelines recommend that there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. The 4 A's for ongoing monitoring for this medication were not reported. Continued use of this medication would not be supported. Therefore, this request is not medically necessary.