

Case Number:	CM14-0179698		
Date Assigned:	11/04/2014	Date of Injury:	08/13/2012
Decision Date:	12/09/2014	UR Denial Date:	10/13/2014
Priority:	Standard	Application Received:	10/29/2014

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 Physical Medicine & Rehabilitation and Pain Medicine 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 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 51-year-old female who reported an injury on 08/13/2012. The mechanism of injury was not submitted for review. The injured worker had a diagnosis of chronic pain, sprain of the sacroiliac on the right side, and spasm of muscle right piriformis. No diagnostics were submitted for review. Past medical treatment consisted of physical therapy and medication therapy. On 08/22/2014, the injured worker complained of lumbar spine pain. It was noted that the injured worker rated the pain at a 4/10. It was noted on physical examination that there was movement loss to the lumbar spine with flexion, extension, rotation to the left, rotation to the right, lateral left, and lateral right. Hip flexion was 4/5 bilaterally, extension was 4/5 bilaterally, and abduction was 4/5 bilaterally. The medical treatment plan was for the injured worker to continue with medication therapy. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 4mg #60 +2 refills (prescribed 10-1-14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

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

Decision rationale: The request for tizanidine 4 mg is not medically necessary. The California MTUS Guidelines recommend tizanidine as a non-sedating muscle relaxant with caution as a second line option for the short term treatment of acute exacerbations in patients with chronic low back pain. They show no benefit beyond NSAIDs in pain and overall improvement and efficacy appears to diminish over time. Prolonged use of some medications in this class may lead to dependence. The documentation indicated that the injured worker had been on tizanidine since at least 08/2012, exceeding the recommended guidelines for short term use. Additionally, the efficacy of the medication was not submitted for review. Furthermore, the request as submitted is for tizanidine 4 mg with a quantity of 60 plus 2 refills, also exceeding the recommended guidelines for short term use. There was no rationale submitted for review indicating the continuation of the medication. Given the above, the request is not medically necessary.

Ultracet three times per day as needed #90 +1 refill (prescribed 10-1-14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultracet, Ongoing management Page(s): 82, 93, 94, 113, 78.

Decision rationale: The request for Ultracet is not medically necessary. The submitted documentation did not indicate the efficacy of the medication, nor did it indicate that it was helping with any functional deficits the injured worker might have had. According to the California MTUS Guidelines, Ultracet is a central analgesic drug used for managing neuropathic pain. There was no diagnosis submitted in the reports congruent with the recommended guidelines. Additionally, there was no assessment indicating what pain levels were before, during, and after medication administration. There were no urinalyses or drug screens submitted for review showing that the injured worker was compliant with medications. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

Celebrex 200mg daily #30 +2 refills (prescribed 10-1-14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Celebrex Page(s): 30.

Decision rationale: The request for Celebrex 200 mg is not medically necessary. The provided documentation did not indicate the efficacy of the medication, nor did it indicate that the Celebrex was helping with any functional deficits the injured worker had. Celebrex is a nonsteroidal anti-inflammatory drug, which is a Cox 2 inhibitor that does not interfere with

aspirins and antiplatelet activity. Cox 2 inhibitors have a decreased risk for gastrointestinal events and at risk patients. NSAIDs are not recommended for the treatment of long term neuropathic pain. The submitted documentation indicated that the injured worker had been on Celebrex since at least 2012, exceeding the recommended guidelines for short term use. Additionally, there was no evidence of the injured worker being at increased risk for gastrointestinal events. Given the above, the injured worker is not within the MTUS recommended guidelines criteria. As such, the request is not medically necessary.