

Case Number:	CM14-0026538		
Date Assigned:	06/13/2014	Date of Injury:	06/15/2006
Decision Date:	10/08/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	03/03/2014

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 and Rehabilitation, 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 60-year-old male, who reported injury on 06/15/2006 due to a slip and fall. The injured worker has diagnoses of pain in joint shoulder, pain in joint forearm, pain in joint lower leg, and pain in joint ankle foot. Past medical treatment consists of open reduction internal fixation, physical therapy, and medication therapy. Medications include Zanaflex, Cymbalta, and buprenorphine HCl. On 01/14/2009, the injured worker underwent an x-ray of the right clavicle, which revealed subacute to chronic appearing non-united complex mid right clavicular fracture. On 06/17/2014, the injured worker reported that there was no acute change in the knee, shoulder, and elbow pain. It was noted in the physical exam that the injured worker's pain was an 8/10 on VAS with medications and 10+/10 without. Examination of the right lower extremity revealed atrophy. It was noted that there was normal muscle tone without atrophy in the right and left upper extremity. There was also normal muscle tone without atrophy in the left lower extremity. Examination of muscle strength revealed lower leg flexion 3/5, lower leg extension 3/5, ankle dorsiflexion 3/5, and ankle plantar flexion 3/5. There was no edema or tenderness to palpation in any extremity. The submitted documentation lacked any indication of range of motion. The treatment plan is for the injured worker to continue the use of Zanaflex and Cymbalta. Provider feels that the injured worker is generally stable with the use of his medications. The Request for Authorization form was submitted on 03/10/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) prescription of Tizanidine-Zanaflex 4mg #90: Upheld

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

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

Decision rationale: The request for ONE (1) PRESCRIPTION OF TIZANIDINE-ZANAFLEX 4MG #90 is not medically necessary. The California MTUS Guidelines recommend Zanaflex as a non-sedating muscle relaxant with caution as a second line option for short term treatment for 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. Documentation, dated 07/17/2013, showed that the injured worker was prescribed Zanaflex since at least this time. Furthermore, the request as submitted is for Zanaflex 4 mg with a quantity of 90, exceeding the recommended guidelines of short term use for the medication. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request for ONE (1) PRESCRIPTION OF TIZANIDINE-ZANAFLEX 4MG #90 is not medically necessary.

One (1) prescription of Cymbalta 60mg #60 with five (5) refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 43.

Decision rationale: The request for ONE (1) PRESCRIPTION OF CYMBALTA 60MG #60 WITH FIVE (5) REFILLS is not medically necessary. The California MTUS Guidelines recommend Cymbalta as an option in first line treatment for neuropathic pain. The assessment of treatment efficacy should include not only pain outcomes but also an evaluation of function, changes in use of other analgesic medications, sleep quality and duration, and psychological assessment. There was a lack of documented evidence of the efficacy of the injured worker's medications. Additionally, the request as submitted did not indicate a frequency of the medication. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request for ONE (1) PRESCRIPTION OF CYMBALTA 60MG #60 WITH FIVE (5) REFILLS is not medically necessary.