

<b>Case Number:</b>	CM14-0071567		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	11/24/2008
<b>Decision Date:</b>	08/22/2014	<b>UR Denial Date:</b>	04/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/17/2014

### 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 Physical Medicine and Rehabilitation & Pain Management, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and 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 injured worker is a 52-year-old female who reported an injury on 11/24/2008. The mechanism of injury is not submitted in the report. The injured worker has diagnoses of left L5 lumbar radiculitis, status post fusion, status post fusion L5-S1, and bilateral sacroiliitis. Past medical treatment includes physical therapy, heating packs, ice, TENS unit, epidural injections, and medication therapy. A CT scan done 01/2013 revealed solid fusion of L4-S1 and moderate adjacent segment disease with broad-based protrusion of the L4-5. There was also an EMG done on 12/2012, which was abnormal. It revealed evidence of L5 radiculopathy to the left side. The injured worker has a history of lumbar fusion at L5-S1 in 1999 and left shoulder acromioplasty in 2006. The injured worker complained of low back and left lower extremity pain that continued down to her foot. She also described it as achy with numbness and tingling. She rated her pain at a 7/10. The injured worker had a history of lumbar fusion and epidurals at the L4-5 level, which did alleviate the pain for approximately 6 weeks. The injured worker also complained of a stabbing pain to her left shoulder, which she also rated at a 7/10 pain. Physical examination dated 03/31/2014 revealed that the injured worker's lower spine had decreased range of motion in all planes. There was tenderness to palpation of the bilateral lumbar paraspinous muscles as well as over the sacroiliac joints bilaterally. Motor strength testing of the left revealed 4+5 with dorsal and plantar flexion and 4+/5 in the left quads and hamstrings. Sensation was diminished to light touch along the left L5 dermatome. Reflexes of deep tendons were symmetrical bilaterally. Medications include tramadol ER 150 mg, amitriptyline HCl 10 mg, orphenadrine citrate 100 mg, hydrocodone/APAP 10/325 mg, and Nor flex ER 100 mg. The treatment plan discussed with the injured worker was of the left L5 radiculopathy, recommended psychological clearance for a trial of a spinal cord stimulator. The stimulator would primarily cover the neuropathic pain effect

in the lower extremity; however, it may be beneficial for her axial low back pain as well. The provider would also like to continue to request authorization for a pain psychology consultation prior to DCS trial. As far as the chronic pain of the injured worker, the medications will provide would be Norco 10/326, Zanaflex 4 mg, Cymbalta 60 mg, Ultram 50 mg, and Lyrica 150 mg. The risks, benefits, and potential complications of the medications were discussed with the injured worker, and the injured worker states understanding. The Request for Authorization form was submitted on 02/05/2014.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**ULTRAM 50 MG #90 ONE REFILL:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Tramadol (Ultram) Page(s): 78, 93-94..

**Decision rationale:** The injured worker complained of low back and left lower extremity pain that continued down to her foot. She also described it as achy with numbness and tingling. She rated her pain at a 7/10. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that for any opioids such as, Ultram, the 4 A's must be followed for Ongoing Monitoring. These four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or no adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). Side effects to include dizziness, nausea, constipation, headache, somnolence, flushing, pruritus, vomiting, insomnia, dry mouth, and diarrhea. Also the use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control should be in effect. Ultram is indicated for moderate to severe pain. The recommended release formulation is a dose of 50 to 100mg PO every 4 to 6 hours. Given the above guidelines, the injured worker is not within MTUS Guidelines. There was no documentation regarding a measurement of pain of the injured worker with and without the Ultram. There were no side effects listed in the reports. The report also lacked any urinalysis or drug screens showing that the injured worker was compliant with the MTUS guidelines. The request as submitted also failed to list frequency and duration of the Ultram. As such, the request for ultram 50 mg #90 one refill is not medically necessary and appropriate.

**ZANAFLEX 4 MG #60 ONE REFILL:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (Zanaflex) Page(s): 63-64,66.

**Decision rationale:** The injured worker complained of low back and left lower extremity pain that continued down to her foot. She also described it as achy with numbness and tingling. She rated her pain at a 7/10. The California MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most Low Back Pain (LBP) cases, they show no benefit beyond Non-Steroidal Anti-Inflammatory Drugs (NSAID)'s in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. Given the above, the request is not within the MTUS Guidelines. There is no assessment regarding functional improvement as a result of the medication (Zanaflex). There was no evidence of the injured worker having trialed and failed any first line treatment therapy. In addition, there was no mention of a lack of side effects. It was noted in the report that the medication helped with deficits that the injured worker might have had, but as per guidelines, Zanaflex is not recommended for long term use. Plus the efficacy of the medication is diminished over time. Furthermore, the request for the ongoing use of Zanaflex did not include a frequency, and is not supported by the California Medical Treatment Utilization Schedule Guideline recommendations. As such, the request for Zanaflex 4 mg #60 one refill is not medically necessary and appropriate.