

Case Number:	CM14-0078980		
Date Assigned:	07/18/2014	Date of Injury:	07/31/2008
Decision Date:	09/08/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/29/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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 claimant is a 55 year old female presenting with chronic pain following a work related injury on 07/31/2008. The claimant complained of left knee pain associated with swelling. The pain and swelling is associated with difficulty walking. The physical exam showed pain and tenderness of the cervical spine, more on the right than on the left side, range of motion produced pain, mildly limited, on-going diminished right C6-7 sensation, pain and tenderness over the anterior and lateral deltoid as well as over the acromioclavicular joint, which is moderate, positive O'Brien's maneuver, range of motion testing produced pain, tenderness of the lumbar spine has tenderness to palpation over the bilateral paraspinals, more on the left than on the right, limited range of motion secondary to pain, positive straight leg raise, bilateral leg raise, decrease dermatomal sensation at L5-S1 bilateral lower extremities, left knee with mild swelling and pain to palpation in the bilateral knee joint lines. The claimant was diagnosed with cervical spine strain/sprain rule out discopathy, rule out right upper extremity radiculopathy, rule out right cubital tunnel syndrome, status post right shoulder arthroscopy, right sternoclavicular subluxation, right medial/lateral epicondylitis, status post left middle finger trigger release and status post bilateral thumb trigger release surgeries, lumbar spine strain/sprain, rule out discopathy, status post left cubital tunnel release, lumbar spine strain/sprain rule out radiculopathy, left knee sprain/strain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4mg #60 with 2 refills.: Upheld

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

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

Decision rationale: Tizanidine (Zanaflex) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) 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. (Malanga, 2002) May also provide benefit as an adjunct treatment for fibromyalgia. (ICSI, 2007). The recommended dosing is 4mg with a max dose of 36 mg per day. The medical records indicate that the zanaflex was prescribed for back pain. MTUS recommends short term use for myofascial pain or fibromyalgia; therefore, the request is not medically necessary.

Norco 10/325 mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79.

Decision rationale: Per MTUS Page 79 of CA MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. In fact, the medical records note that the claimant was permanent and stationary. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; therefore Norco is not medically necessary.

Tramadol 150 mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 79-83.

Decision rationale: Per MTUS page 83, opioids for osteoarthritis are recommended for short-term use after failure of first line non-pharmacologic and medication option including Acetaminophen and NSAIDS. Additionally, Page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are

extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. In fact, the claimant continued to report pain. Given Tramadol is a synthetic opioid, its use in this case is not medically necessary. The claimant has long-term use with this medication and there was a lack of improved function or return to work with this opioid. Therefore the request is not medically necessary.

Omeprazole: Upheld

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

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

Decision rationale: CA MTUS does not make a direct statement on proton pump inhibitors (PPI) but in the section on NSAID use page 67. Long term use of PPI, or misoprostol or Cox-2 selective agents have been shown to increase the risk of Hip fractures. CA MTUS does state that NSAIDs are not recommended for long term use as well and if there possible GI effects of another line of agent should be used for example acetaminophen. There is no documentation of gastrointestinal disorder requiring PPI or the use of NSAID associated gastrointestinal disorder. Omeprazole is therefore, not medically necessary.

Tizanidine 4 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-spasmodics, page(s) <Insert Page Number or Numbers>.

Decision rationale: Tizanidine (Zanaflex) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) 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. (Malanga, 2002) May also provide benefit as an adjunct treatment for fibromyalgia. (ICSI, 2007). The recommended dosing is 4mg with a max dose of 36 mg per day. The medical records indicate that the Zanaflex was prescribed for back pain. MTUS recommends short term use for myofascial pain or fibromyalgia; therefore, the request is not medically necessary.

Transdermal medication: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Insert Section (for example Knee)>, <Insert Topic (for example Total Knee Arthroplasty)>.

Decision rationale: According to California MTUS, 2009, chronic pain, page 111 California MTUS guidelines does not cover "topical analgesics that are largely experimental in use with a few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended". Additionally, the requested trans-dermal medication does not indicate the specific compound; therefore the requested medication is not medically necessary.