

Case Number:	CM14-0085853		
Date Assigned:	07/23/2014	Date of Injury:	05/15/2008
Decision Date:	10/01/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	06/09/2014

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 Tennessee. 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:

This is a 48-year-old female with a 5/15/08 date of injury. The mechanism of injury occurred when the patient was stopped at a red light and was rear-ended. According to a progress report dated 6/4/14, the patient stated that her pain was currently located at her cervical, thoracic, lumbar regions and right shoulder. She stated that without pain medications, her pain level would be 8/10 and with pain medications, her pain level was 0/10. She stated that she was currently receiving about 90% pain relief with her current medications. Objective findings: moderate palpable spasms bilateral cervical paraspinal muscles and bilateral trapezius with positive twitch response. Diagnostic impression: cervicalgia, myofascial pain syndrome. Treatment to date: medication management, activity modification. A UR decision dated 5/14/14 denied the requests for Tramadol, Tylenol #3, Celebrex, and Zanaflex. A specific rationale for denial was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2
Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The patient is also taking another opioid medication, Tylenol #3. Guidelines do not support the use of multiple short-acting opioid medications. In addition, the patient's injury is over 6 years old. There is no discussion regarding non-pharmacologic methods the patient has tried for her pain. Furthermore, it is not noted whether or not the patient has returned to work. Therefore, the request for Tramadol 50mg #180 was not medically necessary.

Tylenol #3 #90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The patient is also taking another opioid medication, Tramadol. Guidelines do not support the use of multiple short-acting opioid medications. In addition, the patient's injury is over 6 years old. There is no discussion regarding non-pharmacologic methods the patient has tried for her pain. Furthermore, it is not noted whether or not the patient has returned to work. Therefore, the request for Tylenol #3 #90 was not medically necessary.

Celebrex 200mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Other Medical Treatment Guideline or Medical Evidence: FDA (Celebrex) JAMA September 13, 2000, Vol 284, No. 10

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines states that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain, and that Celebrex may be considered if the patient has a risk of GI complications, but not for the majority of patients. The FDA identifies that Celebrex is indicated in the treatment of osteoarthritis, rheumatoid arthritis, acute pain, and familial adenomatous polyposis. In addition, Celebrex is also a better choice than NSAIDs in patients with osteoarthritis and rheumatoid arthritis who are on a daily aspirin with regard to prophylaxis of GI complications as the annual

GI complication rates for these patients is significantly reduced. There is no documentation that the patient has had a trial and failed a first-line NSAID. In addition, there is no documentation that the patient has gastrointestinal complaints or at increased risk of gastrointestinal complications. Therefore, the request for Celebrex 200mg #30 was not medically necessary.

Zanaflex 4mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 63-66.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity and off label use for low back pain. In addition, MTUS also states that muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs 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. It is noted that the patient has been taking Zanaflex since at least 2/11/14. Guidelines do not support the long-term use of muscle relaxants. In addition, there is no documentation of an acute exacerbation to the patient's pain. Therefore, the request for Zanaflex 4mg #90 was not medically necessary.