

Case Number:	CM14-0192027		
Date Assigned:	11/25/2014	Date of Injury:	06/05/2012
Decision Date:	01/12/2015	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	11/17/2014

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, has a subspecialty in Interventional Spine 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 patient is 44 a year old female with an injury date on 06/05/2012. Based on the 09/30/2014 progress report provided by the treating physician, the diagnoses are:1. Status post right wrist carpal tunnel release on 07/28/2014.2. Right wrist carpal tunnel syndrome, positive per EMG/NCS. According to this report, the patient complains of pain in the "cervical, thoracic and lumbar spine, right wrist, left shoulder and arm, resulting in emotional stress." Pain in the right wrist is a 6-7/10 and can increase to a 10/10 with palpation or range of motion. Physical exam reveals some localized erythema directly surrounding the right wrist surgical scar. Range of motion of the right wrist is restricted with discomfort over the volar aspect of the wrist. Tenderness is noted throughout the volar aspect of the right wrist and hand. The patient's works status "is to remain on total temporary disability" until re-evaluated. The 08/21/2014 report indicates patient's neck/low back pain is an 8/10 and mid back pain is a 7/10. Patient has "limited range of motion while moving around, standing, walking, sitting, bending, pulling, turning from side to side, carrying, twisting, and bending down doing chores, and driving." There were no other significant findings noted on this report. The utilization review denied the request for Tramadol 50 mg # 90 and Tizanidine 4 mg # 30 on 10/22/2014 based on the MTUS guidelines. The requesting physician provided treatment reports from 05/15/2014 to 09/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50 mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, Criteria for use of opioids Page(s): 60-61, 76-78, 88-89.

Decision rationale: In reviewing of the reports, there is documentation of analgesia with pain ranging from 10/10 to 6/10. "The patient states that she is currently utilizing Tramadol 50 mg for her postoperative pain. She describes good overall symptomatic relief when utilizing that medication." Patient has "Limited range of motion while moving around, standing, walking, sitting, bending, pulling, turning from side to side, carrying, twisting, and bending down doing chores, and driving." Other than these, the documentation lack discussion regarding side effects, other opiates management issues such as urine toxicity, CURES, and behavioral issues. Outcomes measures are not documented as required by MTUS. No valid instruments are used to measure the patient's function which is recommended once at least every 6 months per MTUS. In this case, the treating physician has failed to properly document ADL's, Adverse effects and Adverse behavior as required by MTUS. The request is not medically necessary.

Tizanidine 4 mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic drugs Page(s): 66.

Decision rationale: According to the 09/30/2014 report, this patient presents with pain in the "cervical, thoracic and lumbar spine, right wrist, left shoulder and arm, resulting in emotional stress." Per this report, the current request is for Tizanidine 4 mg # 30. This medication was first mentioned in the 08/14/2014 report; it is unknown exactly when the patient initially started taking this medication. MTUS guidelines do support Zanaflex for chronic low back pain, myofascial pain and fibromyalgia pains. In this case, given the patient's chronic pain, use of this medication may be indicated. However, the treating physician does not explain how this medication is being used with what effectiveness. The MTUS guidelines page 60 require documentation of medication efficacy when it is used for chronic pain. Therefore, the request is not medically necessary.