MAXIMUS Federal Services

Case Number:	CM14-0033615		
Date Assigned:	06/20/2014	Date of Injury:	08/25/2011
Decision Date:	04/22/2015	UR Denial Date:	03/03/2014
Priority:	Standard	Application Received:	03/17/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Texas, California
Certification(s)/Specialty: Family Practice

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 60-year-old female patient, who sustained an industrial injury on 8/25/11. The current diagnoses include chronic myofascial pain syndrome, lumbar radiculitis, sciatica, cervicobrachial syndrome and gait instability. Per the note dated 1/20/15, she was quite stable and taking prozac and ativan. Per the doctor's note dated 1/7/2015, she has complaints of neck and back pain. Physical examination revealed moderate distress, trigger points palpated across the quadrates lumborum region, upper and lower trapezius region, and sternocleidomastoid area bilaterally and tenderness to palpation in the pes anserine bursa, limited range of motion of the cervical and lumbar spine due to pain in all planes. The medications list includes lorazepam, prozac, dilaudid, lasix, simvastatin, amitiza, tessalon, albuterol inhaler and tizanidine. Treatment to date has included home exercises; functional restoration program; physical therapy; acupuncture and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluoxetine 20 mg #60 X 3 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs (selective serotonin reuptake inhibitors) Page(s): 107.

Decision rationale: According to the CA MTUS chronic pain guidelines cited below SSRIs (selective serotonin reuptake inhibitors) are "Not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. Selective serotonin reuptake inhibitors (SSRIs), a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on controlled trials. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. More information is needed regarding the role of SSRIs and pain. SSRIs have not been shown to be effective for low back pain."Per the records provided patient has had chronic neck and back pain. A detailed clinical and psychological evaluation for anxiety or depression is not specified in the records provided. Response to other treatment for chronic pain like tricyclic antidepressants or antiepileptics is not specified in the records provided. In addition, the patient is taking fluoxetine since long time. Response to patient's symptoms with and without fluoxetine is not specified in the records provided. Fluoxetine 20 mg #60 X 3 refills is not medically necessary.

Tizanidine 4 mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Antispasticity / antispasmodic drugs Page(s): 66.

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

Decision rationale: According to MTUS guidelines "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. 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. May also provide benefit as an adjunct treatment for fibromyalgia." The patient has chronic neck and back pain with the presence of objective findings of limited range of motion and tenderness. Tizanidine is a first line option and is recommended for chronic myofascial pain. The request of Tizanidine 4 mg #90 is deemed medically necessary for this patient.