

<b>Case Number:</b>	CM15-0195474		
<b>Date Assigned:</b>	10/09/2015	<b>Date of Injury:</b>	05/07/2002
<b>Decision Date:</b>	12/29/2015	<b>UR Denial Date:</b>	09/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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: California  
 Certification(s)/Specialty: Emergency Medicine

### 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 50 year old female, who sustained an industrial injury on 5-7-2002. The injured worker was being treated for right knee pain, right trochanteric bursitis, lumbar facet joint arthropathy, lumbosacral radiculopathy, cervicgia, headache, fibromyalgia, and chronic pain syndrome. Medical records (6-25-2015 to 8-24-2015) indicate ongoing low back, bilateral hips, and right knee pain. In addition, the injured worker reported ongoing fibromyalgia and headaches. The injured worker requested to change to Fioricet as her insurance does not cover Imitrex any longer. Her pain was rated an 8. The physical exam (6-25-2015 to 8-24-2015) revealed grossly limited active range of motion of the cervical and lumbar spines, ropy muscle spasms and tenderness in the upper to lower cervical, thoracic, and lumbar paraspinal muscles, and tenderness to palpation of the bilateral sacroiliac joint-sacrum. There was a right-sided antalgic gait, use of a rolling walker for ambulation, positive fibromyalgia tender points, right trochanteric area tenderness, and the right knee was braced. On 8-6-2012, an MRI of the lumbar spine revealed mild diffuse disc bulges from L3-L4 (lumbar 3-lumbar 4) through L5-S1 (lumbar 5-sacral 1), with central annular tears without central canal stenosis or significant neural foraminal narrowing. On 4-10-2015, an MRI of the right knee revealed severe osteoarthritis of the medial joint space compartment, no recurrent medial meniscal tear, and moderate to severe articular cartilage wear-loss in the lateral joint space compartment. There was mild chondromalacia patella, mild cystic degeneration-ganglion formation of the anterior cruciate ligament, and small to moderate knee joint effusion with mild synovitis and synovial debris. Surgeries to date have included 3 knee surgeries. Treatment has included at least 5 sessions of

physical-aquatic therapy, a transcutaneous electrical nerve stimulation (TENS) unit, a right knee injection, right knee bracing, a right greater trochanter injection, and medications including pain (Tramadol Hydrochloride since at least 7-2015), anti-epilepsy, anti-migraine (Imitrex), antidepressant, proton pump inhibitor, histamine 2 antagonist, and muscle relaxant (Tizanidine Hydrochloride since at least 4-2015). On 9-14-2015, the requested treatments included Tizanidine Hydrochloride 4 mg, Tramadol Hydrochloride 50 mg, Acetaminophen-Butalbital-Caffeine 325-50-40 mg, and 18 physical-aquatic therapy sessions. On 9-24-2015, the original utilization review non-certified requests for Tizanidine Hydrochloride 4 mg #60 and Acetaminophen-Butalbital-Caffeine 325-50-40 mg #40, and modified requests for Tramadol Hydrochloride 50 mg #180 and 18 physical-aquatic therapy sessions.

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

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

#### **Tizanidine Hydrochloride 4 mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** The request is for the use of Tizanidine Hydrochloride which is a muscle relaxant. The MTUS Chronic Pain Medical Treatment guidelines under the category of Muscle relaxants states that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. In most cases of low back pain they show no benefit over NSAIDs for pain control. Efficacy appears to diminish over time with the added risk of dependence. In this case the patient has been diagnosed with right knee pain, right trochanteric bursitis, lumbar facet joint arthropathy, lumbosacral radiculopathy, cervicalgia, headache, fibromyalgia, and chronic pain syndrome. Due to the prolonged duration of use, further treatment with Tizanidine would not be guideline supported as medications in this category would only be indicated for short-term treatment. As such, the request is not medically necessary.

#### **Tramadol Hydrochloride 50 mg #180: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**Decision rationale:** The Request is for use of the medication Tramadol which is a centrally acting analgesic. The MTUS Chronic Pain Medical Treatment guidelines under the section Opioids for chronic pain state that for chronic back pain its use appears to be efficacious for short-term pain relief, with long-term efficacy being limited (>16 weeks). Failure to respond to a

time-limited course of opioids has led to the suggestion of consideration of alternative therapy. Also, its use has not been shown to improve function. In this case, the patient has been diagnosed with right knee pain, right trochanteric bursitis, lumbar facet joint arthropathy, lumbosacral radiculopathy, cervicalgia, headache, fibromyalgia, and chronic pain syndrome. There is no documentation revealing improvement in function mentioned. Based on the prolonged duration of opioid use without progressive functional benefit seen, further use would not be guideline supported. As such, the request for the continued use of Tramadol is not medically necessary.

**Acetaminophen/Butalbital/Caffeine 325/50/40mg #40:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Barbiturate-containing analgesic agents.

**Decision rationale:** The request is for the use of Acetaminophen/Butalbital/Caffeine which is a barbiturate containing analgesic medication. The MTUS Chronic Pain Medical Treatment guidelines under the section Barbiturate-containing analgesic agents states that these medications are not recommended for chronic pain due to the potential for drug dependence. There is no evidence which show clinically important enhancement of analgesic efficacy of barbiturate containing analgesics due to the barbiturate constituents. In this case the patient suffers from right knee pain, right trochanteric bursitis, lumbar facet joint arthropathy, lumbosacral radiculopathy, cervicalgia, headache, fibromyalgia, and chronic pain syndrome. The use of Acetaminophen/Butalbital/Caffeine is not guideline supported due the increased risk of dependence and inadequate evidence supporting improved efficacy over non-barbiturate containing analgesics. As such, the use of Acetaminophen/Butalbital/Caffeine is not medically necessary.

**18 physical/aquatic therapy sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Aquatic therapy, Manual therapy & manipulation.

**Decision rationale:** The request is for 18 aquatic physical therapy session. The MTUS guidelines under the sections of Aquatic therapy and Manual therapy & manipulation state that aquatic therapy is indicated as an optional form of exercise if minimizing the effects of gravity is desirable and if land based therapy is not tolerated. In the case the patient has been diagnosed with right knee pain, right trochanteric bursitis, lumbar facet joint arthropathy, lumbosacral radiculopathy, cervicalgia, headache, fibromyalgia, and chronic pain syndrome. There is documentation of intolerance to land based therapy and aquatic treatment is reasonable. At issue is the number of requested sessions. The guidelines state that for low back pain, 6 visits over 2 weeks, and with evidence of functional improvement, a total of 18 visits is indicated. In this case there is inadequate documentation of functional improvement seen to justify further therapy. As such, 18 aquatic physical therapy sessions is not medically necessary.

