

Case Number:	CM15-0031719		
Date Assigned:	02/25/2015	Date of Injury:	03/27/2013
Decision Date:	04/06/2015	UR Denial Date:	02/18/2015
Priority:	Standard	Application Received:	02/19/2015

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: Physical Medicine & Rehabilitation, Pain Management

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 59 year old female, who sustained an industrial injury on 3/27/2013. She reports a fall with a shoulder, knee and back injury. Diagnoses include right shoulder rotator cuff tear and surgical repair (5/30/2014), low back and neck pain and knee pain. Treatments to date include surgery, physical therapy, acupuncture TENS (transcutaneous electrical nerve stimulation), Synvisc knee injection and medication management. A progress note from the treating provider dated 2/5/2015 indicates the injured worker reported right shoulder pain, low back pain and bilateral knee pain. On 2/18/2015, Utilization Review modified the request for Tizanidine Hcl 4 mg with 2 refills to #20 with no refills, Duloxetine Hcl CPEP with 2 refills to a one month supply with no refills and noncertified the request for Triamcinolone Acetonide with 2 refills; citing MTUS and Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine HCL 4 MG 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 Muscle Relaxants (for pain) Page(s): 63-66.

Decision rationale: Regarding the request for tizanidine, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested tizanidine is not medically necessary.

Duloxetine HCL CPEP 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 Antidepressants for chronic pain Page(s): 13-16.

Decision rationale: Regarding the request for duloxetine, CA MTUS states that antidepressants are recommended as a 1st line option for neuropathic pain and as a possibility for non-neuropathic pain. Guidelines go on to recommend a trial of at least 4 weeks. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Within the documentation available for review, there is no identification that the duloxetine provides any specific analgesic effect (in terms of reduced numeric rating scale or percent reduction in pain), objective functional improvement, reduction in opiate medication use, or improvement in psychological well-being. Additionally, if the Cymbalta is being prescribed to treat depression, there is no documentation of current symptoms/findings consistent with depression and evidence of efficacy and functional improvement from prior use of the medication. In the absence of clarity regarding those issues, the currently requested duloxetine is not medically necessary.

Triamcinolone Acetonide with 2 Refills: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/triamcinolone.html>.

Decision rationale: Regarding the request for triamcinolone acetonide, CA MTUS and ODG do not address the issue. FDA indications include inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses. Within the documentation available for review, there is no

current indication of dermatosis or another clear rationale for this treatment. In light of the above issues, the currently requested triamcinolone acetonide is not medically necessary.