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| Case Number: | CM15-0036390 | | |
| Date Assigned: | 03/04/2015 | Date of Injury: | 09/07/2005 |
| Decision Date: | 04/10/2015 | UR Denial Date: | 02/10/2015 |
| Priority: | Standard | Application Received: | 02/26/2015 |

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 57-year-old male who sustained an industrial injury on 09/07/2005. Current diagnoses include degenerative disc disease-lumbar, lumbago, thoracic or lumbosacral neuritis or radiculitis, and lumbosacral spondylosis without myelopathy. Previous treatments included medication management, physical therapy, pneumatic traction unit, and home exercise program. Report dated 02/04/2015 noted that the injured worker presented with complaints that included neck and back pain. Physical examination was positive for abnormal findings. Utilization review performed on 02/10/2015 non-certified a prescription for Tramadol and Tizanidine Hydrochloride, based on the clinical information submitted does not support medical necessity. The reviewer referenced the California MTUS and Official Disability Guidelines in making this decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg #120 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

Decision rationale: Tramadol 50mg #120 with 3 refills is not medically necessary per the MTUS Guidelines. The MTUS Chronic Pain Medical Treatment Guidelines state that a pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The documentation submitted reveals that the patient has been on opioids without significant functional improvement and without clear monitoring of the "4 A's" therefore the request for Tramadol is not medically necessary.

Tizanidine Hydrochloride 2mg, #120 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC pain procedure summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex, generic available) & Muscle relaxants (for pain) Page(s): 66 and 63.

Decision rationale: Tizanidine Hydrochloride 2mg, #120 with 3 refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that muscle relaxants are recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. The documentation indicates that the patient has been on Tizanidine already and the request for 3 refills does not indicate short term use. Furthermore, there is no evidence of functional improvement on prior Tizanidine. Therefore, the request for Tizanidine is not medically necessary.