

Case Number:	CM15-0083761		
Date Assigned:	05/06/2015	Date of Injury:	03/03/2010
Decision Date:	06/10/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	05/01/2015

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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 64 year old female, who sustained an industrial injury on 3/03/2010. Diagnoses include myoligamentous strain of the thoracic spine by history, myoligamentous strain of the lumbar spine with magnetic resonance imaging (MRI) evidence of disc bulge at L3-4 with impingement of the L4 roots bilaterally and status post left shoulder arthroscopic surgery. Treatment to date has included diagnostics, medication and surgical intervention. Per the Primary Treating Physician's Progress Report(s) dated 10/21/2014 and 2/24/2015, the injured worker reported dull to sharp headaches occurring intermittently. She has dull to sharp pain in the neck occurring most of the time radiating to the bilateral trapezius. She also reported dull to sharp pain in the lower back occurring most of the time and radiating to the left leg with numbness, tingling and weakness in the left leg. There was dull to sharp pain in the left shoulder occurring sometimes. Physical examination revealed tenderness upon palpation of the lumbar spine with decreased range of motion to the thoracic spine, lumbar spine and bilateral shoulders. The plan of care included diagnostic imaging and medications. Authorization was requested for Zanaflex and Ultram (dispensed on 1/15/2015.)

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Zanaflex 4mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66 of 127.

Decision rationale: Regarding the request for tizanidine (Zanaflex), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that tizanidine specifically is FDA approved for management of spasticity; unlabeled use for low back pain. Guidelines recommend LFT monitoring at baseline, 1, 3, and 6 months. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the tizanidine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, it does not appear that there has been appropriate liver function testing, as recommended by guidelines. In the absence of such documentation, the currently requested tizanidine (Zanaflex), is not medically necessary.

Retro Ultram 50mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Ultram (tramadol), California Pain Medical Treatment Guidelines state that Ultram is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Ultram (tramadol), is not medically necessary.