

<b>Case Number:</b>	CM14-0153521		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	07/18/2011
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	09/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2014

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient is a 52-year-old male who has submitted a claim for pain in joint, forearm - right distal ulna, sacral disorders L4-L5, sciatica, spinal stenosis, chronic pain; associated with an industrial injury date of 07/18/2011. Medical records from 2014 were reviewed. Patient complained of chronic low back pain and right upper extremity pain. Pain is rated at 8 out of 10. Physical examination of the lumbar spine revealed tenderness to palpation at the lumbosacral junction. Range of motion of the lumbar spine was decreased as well. Treatment to date has included oral medications, such as Tizanidine (since at least March 2014), Tramadol (since at least March 2014), and Naproxen (since September 2014), topical analgesic, such as Diclofenac (since at least March 2014) and physical therapy. Utilization review date of 09/12/14 denied the request for Tizanidine as it was not approved for chronic use of muscle spasms. The request for Diclofenac was also denied as no statement in records stating whether patient failed to respond to oral route NSAIDs or non-tolerance of NSAIDs. The request for Tramadol was also denied because no records included VAS scores and limited functional capacity with respect to pain. The request for Naproxen was also denied because as efficacy is not established, the request is not consistent with the guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tizanidine-Zanaflex 4mg #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain)Antispasticity/Antispasmodic drugs Pa.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines 2009: Tizanidine (Zanaflex, generic available), Page(s): page 63-66.

**Decision rationale:** Page 63-66 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity and off label use for low back pain. In addition, MTUS also states that muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. In this case, tizanidine was prescribed since at least March 2014. However, the medical records do not clearly reflect continued functional benefit from its use. Long-term use is not supported by the guideline. Furthermore, there was no documentation of muscle spasms and acute pain exacerbation. The medical necessity has not been established. There was no clear rationale for continued use of this medication. Therefore, the request for Tizanidine-Zanaflex 4mg #90 is not medically necessary.

**Diclofenac Sodium 1.5 percent 60 Gram #1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical AnalgesicsNon-steroidal antiinflammatory agents (NSAIDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, NSAIDs, Page(s): 111-112.

**Decision rationale:** Page 112 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that topical diclofenac is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). ODG recommends topical diclofenac for osteoarthritis after failure of an oral NSAID or contraindications to oral NSAIDs. In this case, the patient has been taking diclofenac since at least March 2014. He still continues to complain of chronic low back pain. However, there was no objective measurement of his pain when off of his medications. There was also no documentation of functional improvement. The patient has no contraindications to oral NSAID use. In addition, there is no diagnosis of osteoarthritis to support the use of topical NSAIDs. Furthermore, the quantity and frequency of the requested medication are not specified. Therefore the request for Diclofenac Sodium 1.5 percent 60 Gram #1 is not medically necessary.

**Tramadol/APAP 37.5/325mg #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain: Opioids; specific drug list; Opioids, criteria for use

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram), Page(s): page(s) 93-94, 113.

**Decision rationale:** According to page 93-94 and 113 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Tramadol is indicated for moderate to severe pain. In addition, guidelines do not support ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, patient has been taking Tramadol since at least March 2014. There was no documented evidence of pain relief and functional improvement from the medication. In addition, specific measures of analgesia and improvements in activities of daily living were not documented. There was also no documentation of adverse effects. Urinary drug screening was not documented. MTUS Guidelines require clear and concise documentation for ongoing management. Medical necessity has not been established. Therefore, the request for Tramadol/APAP 37.5mg #90 is not medically necessary.

**Naproxen Sodium-Anaprox 550mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68, 73.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines , NSAIDs, Page(s): page 46.

**Decision rationale:** As stated on page 46 of the California MTUS Chronic Pain Medical Treatment guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. In this case, patient complained of chronic low back pain. Patient has been prescribed Naproxen since September 2014. However, patient reported that naproxen failed to provide him symptom relief, based from progress report dated 10/8/2014. There is no clear indication for continuing treatment at this time. Therefore, the request for Naproxen Sodium-Anaprox 550mg #90 is not medically necessary.