

Case Number:	CM14-0160441		
Date Assigned:	10/06/2014	Date of Injury:	03/10/1999
Decision Date:	10/31/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	09/30/2014

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 California. 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:

According to the records made available for review, this is a 53-year-old male with a 3/10/99 date of injury. At the time (8/14/14) of request for authorization for Tizanidine 4mg #90 with 12 refills, Anaprox DS 550mg #100, Neurontin 1200mg #100, Cymbalta 60mg #30 with 12 refills, and Tylenol 1000mg #100 with 12 refills, there is documentation of subjective (right shoulder pain radiating to elbow and neck, thoracic, and low back pain) and objective (diminished sensation in the medial right leg, right 5th digit and right axilla and decreased right shoulder flexion and abduction) findings, current diagnoses (cervical radiculopathy, rotator cuff sprain, and lumbar strain), and treatment to date (medications (including ongoing treatment with Tizanidine, Anaprox, Neurontin, Cymbalta, and Tylenol since at least 3/6/14)). Medical report identifies that the patient has depression. In addition, medical reports identify that Cymbalta and Neurontin allow the patient to walk longer, stand longer, and move around better. Furthermore, medical reports identify that Tizanidine is prescribed for periods of acute exacerbation of chronic low back pain. Lastly, medical reports identify that Anaprox and Tylenol provide 30% pain relief. Regarding Tizanidine, there is no documentation of spasticity; short-term (less than two weeks) treatment; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Tizanidine use to date. Regarding Anaprox, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Anaprox use to date. Regarding Tylenol, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Tylenol use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 4mg #90 with 12 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain Page(s): 55, 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs (Tizanidine (Zanaflex)) Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain)

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of spasticity, as criteria necessary to support the medical necessity of Tizanidine. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of cervical radiculopathy, rotator cuff sprain, and lumbar strain. In addition, given documentation that there is ongoing treatment with NSAID, there is documentation of Tizanidine use as a second-line treatment. However, despite documentation that Tizanidine is prescribed for periods of acute exacerbation of chronic low back pain, there is no documentation of spasticity. In addition, given documentation of Tizanidine prescription since at least 3/6/14, and a prescription for Tizanidine 4mg #90 with 12 refills, there is no documentation of short-term (less than two weeks) treatment. Furthermore, given documentation of ongoing treatment with Tizanidine, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Tizanidine use to date. Therefore, based on guidelines and a review of the evidence, the request for Tizanidine 4mg #90 with 12 refills is not medically necessary.

Anaprox DS 550mg #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's (non-steroidal anti-inflammatory) Page(s): 67-70.

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase

in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical radiculopathy, rotator cuff sprain, and lumbar strain. In addition, there is documentation of pain and ongoing treatment with Anaprox. However, despite documentation that Anaprox provides 30% pain relief, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Anaprox use to date. Therefore, based on guidelines and a review of the evidence, the request for Anaprox DS 550mg #100 is not medically necessary.

Neurontin 1200mg #100: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AED's) Page(s): 16-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (Gabapentin). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical radiculopathy, rotator cuff sprain, and lumbar strain. In addition, there is documentation of neuropathic pain and ongoing treatment with Gabapentin. Furthermore, given documentation that Neurontin allows the patient to walk longer, stand longer, and move around better, there is documentation of functional benefit and improvement as an increase in activity tolerance as a result of Neurontin use to date. Therefore, based on guidelines and a review of the evidence, the request for Neurontin 1200mg #100 is medically necessary.

Cymbalta 60mg #30 with 12 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 43-44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Antidepressants for chronic pain

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines state Cymbalta is a norepinephrine and serotonin reuptake inhibitor antidepressant (SNRIs). In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of depression, generalized anxiety disorder, or pain related to diabetic neuropathy, as criteria necessary to support the medical necessity of Cymbalta. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications

or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical radiculopathy, rotator cuff sprain, and lumbar strain. In addition, there is documentation of depression and ongoing treatment with Cymbalta. Furthermore, given documentation that Cymbalta allows the patient to walk longer, stand longer, and move around better, there is documentation of functional benefit and improvement as an increase in activity tolerance as a result of Cymbalta use to date. Therefore, based on guidelines and a review of the evidence, the request for Cymbalta 60mg #30 with 12 refills is medically necessary.

Tylenol 1000mg #100 with 12 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Harrison's Principles of Internal Medicine 14th Edition: Cardinal.

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical radiculopathy, rotator cuff sprain, and lumbar strain. In addition, there is documentation of pain and ongoing treatment with Tylenol. However, despite documentation that Tylenol provides 30% pain relief, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Tylenol use to date. Therefore, based on guidelines and a review of the evidence, the request for Tylenol 1000mg #100 with 12 refills is not medically necessary.