

Case Number:	CM15-0126994		
Date Assigned:	07/13/2015	Date of Injury:	03/19/1985
Decision Date:	08/07/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/01/2015

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

Certification(s)/Specialty: Emergency 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 (n) 60-year-old female, who sustained an industrial injury on 3/19/85. She reported pain in her neck and upper extremities. The injured worker was diagnosed as having C2-C7 herniated nucleus pulposus, mild thoracic spine herniated nucleus pulposus and bilateral upper extremity numbness. Treatment to date has included acupuncture with no benefit. The treating physician noted that at one time the injured worker was authorized for neck surgery but had to cancel due to a family emergency. Current medications include Tylenol #3, Gabapentin and Tizanidine since at least 6/26/14. As of the PR2 dated 5/18/15, the injured worker reports significant neck and bilateral upper extremity pain. She also states that for three weeks, she has had dizziness, balance problems and occipital headaches. Objective findings include mild torticollis, tenderness with cervical range of motion and a positive Spurling's maneuver. The treating physician requested to continue Tizanidine 4mg #60 x 2 refills and to start Amitriptyline/Tramadol/Dextromethorphan 4%/20%/10% cream #240gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 4mg #60 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Page63-66 Page(s): 63-66.

Decision rationale: The requested Tizanidine 4mg #60 with 2 refills is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Muscle Relaxants, Page 63-66, do not recommend muscle relaxants as more efficacious than NSAIDs and do not recommend use of muscle relaxants beyond the acute phase of treatment. The injured worker has significant neck and bilateral upper extremity pain. She also states that for three weeks, she has had dizziness, balance problems and occipital headaches. Objective findings include mild torticollis, tenderness with cervical range of motion and a positive Spurling's maneuver. The treating physician has not documented duration of treatment, spasticity or hypertonicity on exam, intolerance to NSAID treatment, or objective evidence of derived functional improvement from its previous use. The criteria noted above not having been met, Tizanidine 4mg #60 with 2 refills is not medically necessary.

Amitriptyline/Tramadol/Dextromethorphan 4%/20%/10% cream #240gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page 111-113, Topical Analgesics Page(s): 111-113.

Decision rationale: The requested Amitriptyline/Tramadol/Dextromethorphan 4%/20%/10% cream #240gm, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has significant neck and bilateral upper extremity pain. She also states that for three weeks, she has had dizziness, balance problems and occipital headaches. Objective findings include mild torticollis, tenderness with cervical range of motion and a positive Spurling's maneuver. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Amitriptyline/Tramadol/Dextromethorphan 4%/20%/10% cream #240gm is not medically necessary.