

Case Number:	CM15-0176874		
Date Assigned:	09/17/2015	Date of Injury:	03/24/2011
Decision Date:	10/20/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/08/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal 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:

This is a 55 year old male with a date of injury on 3-24-2011. A review of the medical records indicates that the injured worker is undergoing treatment for status post lumbar spine fusion, left groin hernia-varicocele and insomnia due to pain. According to the progress report dated 8-21-2015, the injured worker complained of constant pain in his lower back traveling to his lower extremities. He rated his pain as seven out of ten. He also complained of numbness and tingling in the lower extremities. He reported that his pain levels had decreased following surgery, but he still required medication to control his post-surgical residual pain over his left buttock. He reported that his medications were helpful. The physical exam (8-21-2105) revealed positive straight leg raise bilaterally. There were sensory deficits corresponding to the L1-S2 dermatomes. Range of motion of the lumbar spine was limited by pain and spasm. Treatment has included lumbar fusion, physical therapy and medications. Current medications (8-21-2015) included Ultram, Gabapentin, Oxycontin and Tizanidine. The request for authorization dated (8-21-2015) included Zanaflex and Gabapentin. The original Utilization Review (UR) (8-27-2015) modified a request for Gabapentin 600mg tablet #90 with 4 refills to Gabapentin 600mg #90. Utilization Review non-certified a request for Tizanidine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 600mg tablet #90 with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Anti-epilepsy drugs (AEDs), Gabapentin.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Gabapentin 600 mg #90 with four refills is not medically necessary. Gabapentin is recommended for some neuropathic pain conditions and fibromyalgia. Gabapentin is associated with a modest increase in the number of patients experiencing meaningful pain reduction. Gabapentin is an anti-epilepsy drug. In this case, the injured worker's working diagnoses are status post lumbar spine fusion; left groin hernia/varicocele; and insomnia due to pain. Date of injury is March 24, 2011. Request for authorization is August 21, 2015. According to the progress note dated March 12, 2015, current medications included gabapentin 600 mg. According to the progress note dated June 4, 2015, current medications included Tizanidine 4 mg. Additional medications include tramadol, OxyContin, and oxycodone. According to the most recent progress note dated August 21, 2014, subjective complaints included low back pain with radiation to the lower extremity. Pain score was 7/10. There was no documentation demonstrating objective functional improvement with ongoing gabapentin. There was no subjective improvement. Additionally, the treating provider requested #4 refills in addition to the one month supply. This is an excessive number of gabapentin 600 mg based on the lack of an appropriate clinical response. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation demonstrating objective functional treatment and an excessive number of refills, Gabapentin 600 mg #90 with four refills is not medically necessary.

Tizanidine 4mg tablet #120 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Muscle relaxants.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Tizanidine 4mg #120 with #4 refills is not medically necessary. Muscle relaxants are recommended as a second line option short-term (less than two weeks) of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time and prolonged use may lead to dependence. In this case, the injured worker's working diagnoses are status post lumbar spine fusion; left groin hernia/varicocele; and insomnia due to pain. Date of injury is March 24, 2011. Request for authorization is August 21, 2015. According to the progress note dated March 12, 2015, current medications included gabapentin 600 mg. According to the progress note dated June 4, 2015, current medications included Tizanidine 4 mg. Additional medications include tramadol, OxyContin, and oxycodone. According to the most recent progress note dated August 21, 2014, subjective complaints included low back pain with radiation to the lower extremity. Pain score was 7/10. There was no documentation demonstrating objective functional improvement to

support ongoing Tizanidine 4 mg. Muscle relaxants are recommended as a second line option short-term (less than two weeks) of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. The treating provider prescribed Tizanidine at a minimum, eight weeks. The guidelines recommend short-term, less than two weeks. The treating provider requested #4 refills in addition to the one month supply. There is no documentation demonstrating objective functional improvement. There is no documentation indicating the presence of acute low back pain or an acute exacerbation of chronic low back pain. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation demonstrating objective functional improvement, no documentation of acute low back pain or an acute exacerbation of chronic low back pain and continued treatment in excess of the recommended guidelines for short-term (less than two weeks) with four refills (an additional five months total), Tizanidine 4mg #120 with #4 refills is not medically necessary.