

Case Number:	CM13-0006577		
Date Assigned:	12/11/2013	Date of Injury:	04/19/2001
Decision Date:	01/17/2014	UR Denial Date:	07/22/2013
Priority:	Standard	Application Received:	08/05/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Cardiology and is licensed to practice in Texas. 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 physician 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:

The patient is a 56-year-old male who reported an injury on 04/19/2001. The patient's diagnoses are listed as lumbar facet joint syndrome, lumbar herniated disc, and lumbar degenerative disc disease. His symptoms include low back pain. His medications include Lyrica 50 mg 1 at bedtime, Norco 10/325 mg every 8 hours as needed for pain, and tizanidine 4 mg at bedtime as needed for muscle spasm. It was noted that the patient continues to rely on Norco, averaging 3 per day, at his 11/25/2013 office visit, and that tizanidine is for persistent intermittent muscle spasm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/Acetaminophen 10/325mg, #90 with 3 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, Ongoing Management, Page(s): 78.

Decision rationale: California MTUS Guidelines state that, for patients who take opioid medications, ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects is required. Additionally, there should be detailed documented

regarding the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. It is stated that the monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. As the clinical documentation submitted for review fails to include documentation regarding the 4 A's for ongoing management of opioid medications, the request is not supported. Therefore, the request is non-certified.

Tizanidine HCL 4mg, #60 with 3 refills: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Tizanidine (Zanaflex, generic available), Page(s): 66.

Decision rationale: California MTUS Guidelines state that Zanaflex is FDA approved for the management of spasticity, as well as frequently used off-labeled for low back pain. It further states that 8 studies have demonstrated efficacy for low back pain, and 1 study demonstrated a significant decrease in pain associated with chronic myofascial pain. The authors of the study recommended its use as a first line option to treat myofascial pain. The patient has been known to have symptoms related to back pain and muscle spasm. Therefore, the requested medication is supported by guidelines. For this reason, the request is certified.