

<b>Case Number:</b>	CM14-0191843		
<b>Date Assigned:</b>	11/25/2014	<b>Date of Injury:</b>	05/29/2013
<b>Decision Date:</b>	01/12/2015	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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 Physical Medicine and Rehabilitation, 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:

This is a female patient with the date of injury of May 29, 2013. A Utilization Review dated October 24, 2014 recommended non-certification of Percocet 10/325 mg #120 1 tab PO Q 6 HRS and Tizanidine 4 mg #120 one to two tabs PO BID PRN. A Progress Report dated September 29, 2014 identifies the Chief Complaint of low back pain and left lower extremity pain. A physical exam identifies tenderness in the mid-line of the lower lumbar spine. Decreased cervical and lumbar spine. There is reduced sensation to light touch along the lateral right thigh and the lateral right leg. The diagnosis is degenerative disc disease, lumbar. The treatment plan is Percocet 10/325, one tablet po q 6 hours prn pain and Tizanidine 4 mg, one to two tablets po bid prn spasm.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325 mg #120 1 tab po q 6 hrs:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120.

**Decision rationale:** Regarding the request for Percocet (Oxycodone/Acetaminophen), the California Pain Medical Treatment Guidelines state that Percocet is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Percocet (Oxycodone/Acetaminophen) is not medically necessary.

**Tizanidine 4 mg #120 one to two tabs po bid prn:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Dosing

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66.

**Decision rationale:** Regarding the request for Tizanidine (Zanaflex), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that Tizanidine specifically is FDA approved for management of spasticity; unlabeled use for low back pain. Guidelines recommend LFT monitoring at baseline, 1, 3, and 6 months. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the Tizanidine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, it does not appear that there has been appropriate liver function testing, as recommended by guidelines. In the absence of such documentation, the currently requested Tizanidine (Zanaflex) is not medically necessary.