

Case Number:	CM14-0206698		
Date Assigned:	12/18/2014	Date of Injury:	07/25/2011
Decision Date:	02/12/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/10/2014

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 Medicine, Hospice and Palliative Care Medicine 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 63 y/o Female who had industrial injury on 7/25/11. Injured worker has seen multiple different specialists since the time of injury. She had an injury going back to 8/15/96. She has obtained physical therapy, x-rays, MRI scans, epidurals, facet injections, surgery, and medications. She had an EMG on 10/31/04 showing a chronic L4 radiculopathy. She underwent a hemilaminectomy and discectomy on 11/11/2003. She returned to full duty at work by March of 2004. However by November of 2004 her pain was increasing. She was working full time and taking medications; vicodin, gabapentin, and prednisone till 7/25/11. A physician felt on 6/20/13 injured worker had signs and symptoms suggestive of fibromyalgia. She subsequently had a spinal cord stimulator trial. On 12/1/14 a non certification recommendation was made for a request of Tizanidine 4mg #120 and Percocet 10/325mg #180. The reviewing physician states, on a report dated 11/27/13, the medications were reviewed and were allowed pending the physician's documentation of adequate documentation as required by guidelines for continued use of the medications. Since no such documentation was available for review, neither medication was recommended for certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 mg, 180 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79, 120.

Decision rationale: Regarding the request for Percocet (Oxycodone/Acetaminophen), MTUS 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 Percocet is improving the patient's function or pain (in terms of percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. In the absence of such documentation, the currently requested Percocet is not medically necessary.

Tizanidine 4 mg, 120 count: Upheld

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

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

Decision rationale: Regarding the request for Tizanidine (Zanaflex), MTUS 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.