

<b>Case Number:</b>	CM15-0006796		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	12/15/1998
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	01/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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: Preventive Medicine, Occupational 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 57 year old female, who sustained an industrial injury on 12/15/1998. She has reported chronic back pain radiating to lower extremities. The diagnoses have included lumbar disc displacement, sciatica, lumbago and chronic pain. Treatment to date included in documentation included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), analgesics, and home exercises. Currently on January 2, 2015, the IW complains of increased back pain associated with increased right leg pain, rated 6-9/10 VAS. Physical examination documented the IW was able to ambulate 10 feet with antalgic gait and then complains of increased burning/sharp pain. Cervical spine with decreased Range of Motion (ROM), tenderness with palpation, along cervical spine and bilateral hips. Plan of care included continuation of previously prescribed medications. On 1/9/2015 Utilization Review modified certification for Zanaflex 4mg #90 and no (0) refills and Norco 10/325mg #180 only, noting the work function was not documented and amount requested exceeded daily doses documented. The MTUS, ACOEM, and ODG guidelines were cited. On 1/13/2015, the injured worker submitted an application for IMR for review of Zanaflex 4mg #180 with two (2) refills and Norco 10/325mg #210.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zanaflex 4mg #180 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants and Antispasticity.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) section Page(s): 63-66.

**Decision rationale:** Zanaflex is FDA approved for the management of spasticity. The use of muscle relaxants for pain is recommended with caution as a second-line option for short term treatment of acute exacerbation in patients with chronic low back pain. There is some support for using Zanaflex in the treatment of myofascial pain syndrome and as an adjunct treatment for fibromyalgia. The injured worker is chronically injured, and has been treated chronically with Zanaflex without evidence of significant benefit. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for Zanaflex 4mg #180 with 2 refills is determined to not be medically necessary.

**Norco 10/325mg #210:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section Weaning of Medications section Page(s): 74-95, 124.

**Decision rationale:** The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The injured worker is chronically injured and has been treated chronically with opioid pain medications. The medical necessity of chronic opioid pain medication is not evident. The injured worker has significant functional limitations and there is not objective functional improvement with the use of opioid pain medications. Urine drug screening has also shown inconsistencies without evaluation of aberrant behavior. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. Utilization review recommended partial certification of this request which would allow for weaning. The request for Norco 10/325mg #210 is determined to not be medically necessary.

