

<b>Case Number:</b>	CM15-0146879		
<b>Date Assigned:</b>	08/07/2015	<b>Date of Injury:</b>	12/01/1999
<b>Decision Date:</b>	09/04/2015	<b>UR Denial Date:</b>	06/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 67 year old female who sustained an industrial injury on December 01, 1999. A pain management follow up visit dated July 30, 2014 reported chief subjective complaint of low back and bilateral leg pain, depression. She states the pain is slowly increasing over the past few months along with a noted weight gain. She is using a wheeled walker more frequently to get around. She does seek psychiatric follow up regarding depression. She is requesting a power scooter with noted discussion regarding plan of care and active mobility is crucial to recovery. Current medications are: Bupropion HCL, Hydrocodone Tylenol 10mg 325 mg, Oxycodone 20mg, Tizanidine, and Prozac. Previous surgical history included: back, spinal cord stimulator trial and permanent implant August and October 2012, and a knee surgery. There is a assigned Opiate agreement. She was diagnosed with the following: myalgia and myositis, post laminectomy syndrome, lumbar, and lumbar radiculopathy. The plan of care noted continuing with current medication regimen and return in 12 weeks. At a follow up dated May 07, 2014 the medication Tizanidine noted discontinued due to no change in spasms or cramping. She is with increased complaint of right lower extremity pain and swelling; scheduled with primary. Oral toxicology screen noted appropriate findings. The plan of care noted recommending a psychological evaluation with treatment per psychiatric evaluation report. The following medications were prescribed this visit: Bupropion HCL, Hydrocodone Tylenol 10mg 325mg, Oxycodone 20mg, and Venlafaxine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone-acetaminophen 10-325mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

**Decision rationale:** Hydrocodone-acetaminophen 10-325mg #120 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that a satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation reveals that the patient has been on long term opioids without significant evidence of functional improvement and with continued significant pain therefore the request for continued Hydrocodone-acetaminophen is not medically necessary.

**Oxycodone 20mg #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

**Decision rationale:** Oxycodone 20mg #90 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that a satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation reveals that the patient has been on long term opioids without significant evidence of functional improvement and with continued significant pain therefore the request for continued Oxycodone is not medically necessary.

**Tizanidine 2mg #180 with 2 refills DOS: 4/8/15: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex, generic available); Muscle relaxants (for pain) Page(s): 66; 63.

**Decision rationale:** Tizanidine 2mg #180 with 2 refills DOS: 4/8/15 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that muscle relaxants are recommend non-sedating muscle relaxants with caution as a second-line option for

short-term treatment of acute exacerbations in patients with chronic low back pain. Tizanidine is a centrally acting alpha<sub>2</sub>-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. The documentation indicates that the patient has chronic low back pain rather than acute. There is no evidence of functional improvement on prior Tizanidine and this medication is intended only for short term use therefore the request for Tizanidine with 2 refills is not medically necessary.