

<b>Case Number:</b>	CM15-0183460		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	04/26/2013
<b>Decision Date:</b>	10/29/2015	<b>UR Denial Date:</b>	08/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2015

### 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: Connecticut, California, Virginia  
 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 47 year old male, who sustained an industrial-work injury on 4-26-13. A review of the medical records indicates that the injured worker is undergoing treatment for chronic lumbar radiculopathy, lumbar facet arthropathy, lumbago and degeneration of lumbar and thoracic intervertebral disc. Medical records dated (2-4-15 to 8-5-15) indicate that the injured worker complains of low back pain that radiates down the right lower extremity (RLE) accompanied by numbness and tingling to the foot. The pain is aggravated by activities. The injured worker also reports frequent muscle spasms in the low back on the right. The pain is rated 8-9 out of 10 with medications and 8-10 out of 10 without medications which has remained unchanged except for the medical record dated 6-10-15 the pain with medications was rated 3 out of 10 with medications for that visit only. The injured worker also reports frequent medication associated gastrointestinal upset and frequent nausea. Per the treating physician report dated 8-5-15 the injured worker has returned to work full time with restrictions. The physical exam dated 8-5-15 reveals that the injured worker has a slow gait and uses a cane to ambulate. There is lumbar spasm noted. There is tenderness to palpation of the lumbar spine, there is decreased flexion and extension due to pain, and the range of motion of the lumbar spine was moderately limited secondary to pain. There is decreased sensitivity to touch along the L3-5 dermatome in the right lower extremity (RLE) and decreased strength. The straight leg raise in seated position was positive on the right for radicular pain at 40 degrees. Treatment to date has included pain medication, Tizanidine and Gabapentin since at least 2-4-15 and Hydrocodone since at least 8-5-15, lumbar epidural steroid injection (ESI) dated 10-28-14 with 50-80 percent improvement for 2 days, physical therapy with no relief, diagnostics, home exercise program (HEP) and work modifications. The treating physician indicates that the urine drug test result dated 7-8-15 was

consistent with the medication prescribed. The request requested services included Tizanidine 2mg #60, Gabapentin 600mg #90 and Hydrocodone 5-325mg #90. The original Utilization review dated 8-17-15 non-certified the request for Tizanidine 2mg #60 as per the guidelines non-sedating muscle relaxants are used with caution for short term treatment of acute exacerbations in chronic low back pain and there is no documentation of acute low back pain. Gabapentin 600mg #90 was non-certified as per the guidelines there is no documented response of at least 30 percent pain reduction and functional improvement with Gabapentin, however discontinuance should include tapering. The request for Hydrocodone 5-325mg #90 was non-certified as per the guidelines there is no documentation of functional improvement that would support the use of the opioid at this time.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Tizanidine 2mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** The MTUS recommends 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. However, in most cases, they seem no more effective than NSAIDs for treatment. There is also no additional benefit shown in combination with NSAIDs. With no objective evidence of pain and functional improvement on the medication based on the provided documents, the quantity of medications currently requested cannot be considered medically necessary and appropriate.

#### **Gabapentin 600mg #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-epilepsy drugs (AEDs).

**Decision rationale:** Anti-epilepsy medications like Neurontin (Gabapentin) are recommended for neuropathic pain; in this case, there is not clear objective evidence of value in use of this medication. Without clear objective improvement in pain (30% decrease) or substantial functional improvement (return to work, etc), it is difficult to justify continued use of the medication. Therefore, without clear evidence for efficacy and uncertainty as to the added clinical value of the drug, the request for gabapentin cannot be considered medically necessary based on the provided records.

#### **Hydrocodone 5/325mg #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment, Opioids, specific drug list, Opioids, steps to avoid misuse/addiction.

**Decision rationale:** Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain in this patient since the initial date of injury, consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate. Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case, the patient clearly warrants close monitoring and treatment, to include close follow up regarding improvement in pain/function; consideration of additional expertise in pain management should be considered if there is no evidence of improvement in the long term. More detailed consideration of long-term treatment goals for pain (specifically aimed at decreased need for opioids), and further elaboration on dosing expectations in this case would be valuable. Consideration of other pain treatment modalities and adjuvants is also recommended. Utilization Review reasonably non-certified the request to facilitate appropriate weaning. Given the lack of clear evidence to support functional improvement on the medication and the chronic risk of continued treatment, the request for hydrocodone is not considered medically necessary.