

<b>Case Number:</b>	CM15-0187535		
<b>Date Assigned:</b>	09/29/2015	<b>Date of Injury:</b>	01/24/2010
<b>Decision Date:</b>	11/12/2015	<b>UR Denial Date:</b>	09/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2015

### 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: Texas, California  
 Certification(s)/Specialty: Family Practice

### 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 injured worker is a 50 year old female, who sustained an industrial injury 01-24-2010. The injured worker was diagnosed as having chronic pain, chronic pain syndrome, hip pain, lumbar disc prolapse with radiculopathy, degeneration of lumbosacral intervertebral disc, osteoarthritis of knee, and displacement of lumbar intervertebral disc without myelopathy and long term drug therapy. On medical records dated 09-01-2015, the subjective complaints were noted as chronic pain. No pain scale was noted on 09-01-2015. Objective findings were noted as lumbar spine revealed spasms to over the lower paraspinals and range of motion was normal. A detailed examination of the right knee on 9/1/15 was not specified in the records specified. Per the note dated 9/1/15 patient was disabled on work and her medication was unchanged and she was barely functioning with current doses. The patient has had history of anxiety, restlessness and sleep disturbances. Treatments to date included medication, laboratory studies and activity as tolerated. Current medications were listed as Aleve, Ativan, Hydrochlorothiazide 25mg, Hydrocodone 10 mg- acetaminophen 325mg, Lexapro 10mg, Oxycodone ER 20mg, Synthroid 125 mcg, Tizanidine 4mg and Voltaren 1 % topical gel. The injured worker was noted to be on Tizanidine, Oxycodone ER and Hydrocodone -APAP since at least 06-2015. The Utilization Review (UR) was dated 09-16-2015. A request for Tizanidine 4mg twice daily as needed #30 with 2 refills #90 was non-certified and Oxycodone ER 20mg every 8 hours #90 and Hydrocodone-APAP 10-325mg every 4-6 hours as needed #150. The UR submitted for this medical review indicated that the request for Tizanidine 4mg twice daily as needed #30 with 2 refills #90 was non-certified and Oxycodone ER 20mg every 8 hours #90 and Hydrocodone-

APAP 10-325mg every 4-6 hours as needed #150 were modified. The patient's surgical history includes right knee arthroplasty on 2/27/13 and arthroscopy in 2008. Patient had received lumbar ESI for this injury. The patient has had UDS on 9/9/15 that was positive for Hydrocodone and Oxycodone and it was consistent. The patient had used a TENS unit for this injury.

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

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

**Tizanidine 4mg twice daily as needed #30 with 2 refills, quantity 90:** Overturned

**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:** Request Tizanidine 4mg twice daily as needed #30 with 2 refills, quantity 90. According to MTUS guidelines, Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study "...demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. May also provide benefit as an adjunct treatment for fibromyalgia." The injured worker was diagnosed as having chronic pain, chronic pain syndrome, hip pain, lumbar disc prolapse with radiculopathy, degeneration of lumbosacral intervertebral disc, osteoarthritis of knee, and displacement of lumbar intervertebral disc without myelopathy and long term drug therapy. On medical records dated 09-01-2015, the subjective complaints were noted as chronic pain. Objective findings revealed spasms over the lower paraspinals. The patient has had history of anxiety, restlessness and sleep disturbances. There is evidence of muscle spasm and other significant abnormal objective findings. The patient's condition is prone to exacerbations. The request for Tizanidine 4mg twice daily as needed #30 with 2 refills, quantity 90 is medically appropriate and necessary in this patient at this time.

**Oxycodone ER 20mg every 8 hours #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, criteria for use.

**Decision rationale:** Oxycodone ER 20mg every 8 hours #90. This is an opioid analgesic. According to CA MTUS guidelines cited below, "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." The records provided do not specify that patient has set goals regarding the

use of opioid analgesic. Other criteria for ongoing management of opioids are: "The lowest possible dose should be prescribed to improve pain and function. Continuing review of the overall situation with regard to non-opioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs." Per the note dated 9/1/15 patient was disabled. The records provided do not provide a documentation of response in regards to functional improvement, to daily-continued use of opioid analgesic for this patient. The continued review of the overall situation with regard to non-opioid means of pain control, including antidepressants meant for chronic myofascial pain, is not documented in the records provided. As recommended by MTUS a documentation of pain relief, functional status, appropriate medication use, and side effects should be maintained for ongoing management of opioid analgesic, these are not specified in the records provided. Whether improvement in pain translated into objective functional improvement, including ability to work is not specified in the records provided. With this, it is deemed that, this patient does not meet criteria for ongoing continued use of opioids analgesic. Oxycodone ER 20mg every 8 hours #90 is not medically necessary for this patient, given the records submitted and the guidelines referenced. If this medication is discontinued, the medication should be tapered, according to the discretion of the treating provider, to prevent withdrawal symptoms.

**Hydrocodone/APAP 10/325mg every 4-6 hours as needed #150:** Overturned

**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, criteria for use.

**Decision rationale:** Hydrocodone/APAP 10/325mg every 4-6 hours as needed #150. This is an opioid analgesic. According to CA MTUS guidelines cited below, "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." Other criteria for ongoing management of opioids are: "The lowest possible dose should be prescribed to improve pain and function. Continuing review of the overall situation with regard to non-opioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects." In addition according to the cited guidelines "Short-acting opioids: also known as 'normal-release' or 'immediate-release' opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain." On medical records dated 09-01-2015, the subjective complaints were noted as chronic pain. The patient's surgical history include right knee arthroplasty on 2/27/13 and arthroscopy in 2008. The patient has had chronic pain and evidence of muscle spasm and other significant abnormal objective findings. The patient's condition is prone to exacerbations. There is no evidence of aberrant behavior. This medication is deemed medically appropriate and necessary to treat any exacerbations of the pain on an as needed/ prn basis. The request of the medication Hydrocodone/APAP 10/325mg every 4-6 hours as needed #150 is medically necessary and appropriate in this patient.