

Case Number:	CM15-0023759		
Date Assigned:	02/13/2015	Date of Injury:	05/20/2001
Decision Date:	03/26/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/09/2015

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: Arizona, 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 63 year old female sustained an industrial injury on 5/20/01, with subsequent ongoing cervical spine pain. Treatment included injections, medications and epidural steroid injections. In a progress note dated 1/28/15, the injured worker complained of neck pain and left leg pain, rated 4-8/10 on the visual analog scale. Physical exam was remarkable for tenderness to palpation from the left trochanter to left inner thigh and left groin to pubic symphysis, cervical and thoracic spine with restricted range of motion, taught and tender trapezius and paravertebral muscles with trigger points and pain with palpation of the left sternocleidomastoid. Current diagnoses included cervicgia, headache, hypertension, trochanetric bursitis, spasm, cervical post-laminectomy syndrome, neck pain, radicular pain and depression. The treatment plan included continuing medications (Fentanyl transdermal, Oxycodone and Tizanidine). On 1/23/15, Utilization Review noncertified a request for Fentanyl 12mcg/hr transdermal patch #15, Oxycodone-Acetaminophen 10/325mg #210 and Tizanidine 4mg #60 with 1 refill citing CA MTUS Chronic Pain Medical Treatment Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl 12mcg/hr transdermal patch #15: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl Page(s): 47.

Decision rationale: According to the guidelines, Fentanyl is an opioid analgesic with a potency eighty times that of morphine. Fentanyl is not recommended as a first-line therapy. The FDA-approved product labeling states that Fentanyl is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. The claimant had been on the medications for months. There was no indication of failure of oral long-acting opioids. Pain scores were stable for months indicating tolerance. Attempt to wean and pain response was not attempted. Continued use of Fentanyl is not medically necessary.

Oxycodone-Acetaminophen 10/325mg #210: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82-92.

Decision rationale: Oxycodone/APAP is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Oxycodone/APAP for several months with a stable pain response and no significant improvement in function. There was no indication of Tylenol failure for break through pain. The continued use of Oxycodone/APAP is not medically necessary.

Tizanidine 4mg #60 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-spasmodics Page(s): 63-64.

Decision rationale: According to the MTUS guidelines, Tizanidine 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. It falls under the category of muscle relaxants. According to the MTUS guidelines, muscle relaxants are to be used with caution as a second-line option for short-term treatment of acute exacerbations in patients with

chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. In this case, the claimant had been on Tizanidine for several months. Continued and chronic use of muscle relaxants /antispasmodics is not medically necessary. Therefore continued and chronic use of Tizanidine is not medically necessary.