

<b>Case Number:</b>	CM15-0035327		
<b>Date Assigned:</b>	03/03/2015	<b>Date of Injury:</b>	11/01/2011
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	01/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2015

### 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: Physical Medicine & Rehabilitation

### 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 33-year-old female sustained a work related injury on 11/01/2011. According to an office visit dated 01/15/2015, the injured worker was seen in follow-up of bilateral upper extremity pain and a pre-operative visit for a recently authorized Cervical Epidural Steroid Injection. Neck pain radiated down to her fingertips in both hands, along the C5 dermatome. She was status post right shoulder arthroscopy and lysis of adhesions on 09/24/2014 and status post debridement and rotator cuff repair on 02/26/2013 and right ulnar nerve release on the right arm and carpal tunnel release on the right wrist. Diagnoses include carpal tunnel syndrome-bilateral, sprains and strains of neck, syndrome cervicobrachial, epicondylitis lateral-bilateral, epicondylitis medial-bilateral, long term use of medications N and therapeutic drug monitor. Medication regimen included Diclofenac Sodium cream, Ketamine 5% cream, Topiramate-Topamax, Hydrocodone and Tizanidine. The injured worker attended physical therapy immediately following surgery, but was unable to continue with the additionally recommended physical therapy due to denial. Her pain level was increased. Plan of care included temporary increase in Norco. On 01/26/2015, Utilization Review non-certified Hydrocodone apap 10/325mg #90 and Tizanidine 4mg #30 retrospective date of service 10/23/2014. According to the Utilization Review physician, in regard to Hydrocodone, there was no documentation indicating complaints of chronic pain. CA MTUS Chronic Pain Medical Treatment Guidelines, pages 78-80, 91 and 124 was referenced. In regard to Tizanidine, there was no indication that the injured worker suffered from myofascial pain syndrome. CA MTUS Chronic Pain Medical Treatment Guidelines, page 66 was referenced. The decision was appealed for an Independent Medical Review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone apap 10/325 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list Page(s): 91, 78-80, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, page(s) 74-96.

**Decision rationale:** Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in functional status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain for this chronic injury without acute flare, new injury, or progressive deterioration. The Hydrocodone apap 10/325 mg #90 is not medically necessary and appropriate.

**Tizanidine 4 mg #30 retrospective date of service: 10/23/14:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/antispasmodic drugs Page(s): 66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, pg 128.

**Decision rationale:** Guidelines do not recommend long-term use of this muscle relaxant for this chronic injury. Additionally, the efficacy in clinical trials has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Submitted reports have not adequately demonstrated the indication or medical need for this treatment and there is no report of significant clinical findings, acute flare-up or new injury to support for its long-term use. There is no report of functional improvement resulting from its previous treatment to support further use as the patient remains unchanged without acute flare-up or clinical

progression. The Tizanidine 4 mg #30 retrospective date of service: 10/23/14 is not medically necessary and appropriate.