

<b>Case Number:</b>	CM15-0041094		
<b>Date Assigned:</b>	03/11/2015	<b>Date of Injury:</b>	04/12/2001
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	02/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/04/2015

### 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:

The injured worker is a 55 year old male, who sustained an industrial injury on 4/12/2001. He reported injury to his low back, while driving a tractor, after hitting a hole. The progress report, dated 8/14/2006, noted a longstanding history of back problems, dating back to 1993. The injured worker was diagnosed as having lumbar disc displacement. Treatment to date has included conservative measures. Currently, the injured worker complains of severe back pain, muscle spasms, and radiating pain and spasm in his right leg. His pain was rated 9/10, at best 4/10 with medications, and 10/10 without. He used a cane for ambulation. Exam of his back revealed spasm and limited range. Motor strength, sensation, and deep tendon reflexes were intact, except altered sensory loss in the right lateral calf and bottom of foot. Medications included Norco and Zanaflex, with refills requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #150:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
CRITERIA FOR USE OF OPIOIDS Hydrocodone Page(s): 76-78, 88-89, 90.

**Decision rationale:** The patient presents with pain and weakness in his lower back and lower extremity. The request is for NORCO 10/325MG #150. Per 02/09/15 progress report, the patient rates his pain as 9/10 at best, 4/10 with medications and 10/10 without medications. "The patient reports 50% reduction in pain, 50% functional improvement with activities of daily living with the medications versus not taking them at all." Per 01/13/15 progress report, "[the patient] is under a narcotic contract" Urine drug screens have been appropriate." The patient has been utilizing Norco since at least 02/06/14. Regarding chronic opiate use, MTUS guidelines page and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's --analgesia, ADLs, adverse side effects, and adverse behavior--, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS guidelines page 90 states that "Hydrocodone has a recommended maximum dose of 60mg/24 hours." In this case, the treater provided drug screening reports. The treater discusses analgesia with 50% improvement and aberrant behavior but the treater doesn't discuss all 4 A's as required by MTUS guidelines. While stating that "improvement with activities of daily living", no specific ADL changes are documented showing significant improvement functionally. General statements regarding ADL's and function are inadequate. Before and after pain scales are used but no validated instruments are used to show functional gains. No outcome measures are provided as required by MTUS. Given the lack of adequate documentation as required by MTUS Guidelines, the request IS NOT medically necessary.

**Zanaflex 4mg #120:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

**Decision rationale:** The patient presents with pain and weakness in his lower back and lower extremity. The request is for ZANAFLEX 4MG #120. The patient has been utilizing Zanaflex since at least 02/06/14. MTUS guidelines page 64-66 recommend muscle relaxants as a short course of therapy. Page 66 specifically discusses Tizanidine (Zanaflex) and supports it for low back pain, myofascial and fibromyalgia pain. In this case, the treater requested Zanaflex for back spasm. The patient does present with low back pain which this medication indicates for. The review of the reports state that "the patient finds Zanaflex is helpful for muscle spasms." Given the benefit from the use of this medication, and the fact that it is allowed for low back pain per MTUS, the request IS medically necessary.