

<b>Case Number:</b>	CM15-0086575		
<b>Date Assigned:</b>	05/08/2015	<b>Date of Injury:</b>	05/25/1990
<b>Decision Date:</b>	06/09/2015	<b>UR Denial Date:</b>	04/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2015

### 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, Pain Management

### 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 63 year old male, who sustained an industrial injury on May 25, 1990. The mechanism of injury was not provided. The injured worker has been treated for lower extremity and left-sided pelvic and groin complaints. The diagnoses have included complex regional pain syndrome of the lower limb, reflex sympathetic dystrophy syndrome of the lower extremity, mononeuritis of the lower limb, chronic pain syndrome and injury to the groin. Treatment to date has included medications, radiological studies and a right total knee replacement. Current documentation dated March 30, 2015 notes that the injured worker reported left-sided pelvic and groin pain. The pain was characterized as sharp, shooting, stabbing and throbbing. The average pain level was a four-six out of ten on the visual analogue scale. Associated symptoms included left groin muscle spasms and weakness of the left lower extremity. The documentation notes the injured workers pain was well controlled with the medications Norco and Oxycodone. The injured workers pain level was noted to increase when the medication are decreased. The treating physician's plan of care included a request for the medications Norco 7.5/325 mg #120 with one refill, Oxycodone 10 mg #60 with one refill and Tizanidine 4 mg # 30 with three refills. Notes indicate that the patient's pain medication reduces his pain and allows him to remain independent with his most basic ADLs including transferring without assistance. Spasms are well controlled with Zanaflex. Physical examination revealed spasm in the left groin with lower extremity weakness. Notes indicate that when pain medication was reduced, his function suffered. Notes indicate that the patient has no aberrant

drug taking behavior, and that urine drug testing has been performed in 2014. The patient reports having a 45% decrease in pain.

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

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

**Tizanidine 4mg #30 with 3 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

**Decision rationale:** Regarding the request for tizanidine (Zanaflex), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that tizanidine specifically is FDA approved for management of spasticity; unlabeled use for low back pain. Guidelines recommend LFT monitoring at baseline, 1, 3, and 6 months. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the tizanidine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, it does not appear that there has been appropriate liver function testing, as recommended by guidelines. In the absence of such documentation, the currently requested tizanidine (Zanaflex) is not medically necessary.

**Norco 7.5/325mg #120 with 1 refill:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

**Decision rationale:** Regarding the request for Norco, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's function and pain with no side effects or aberrant use, and the patient is noted to undergo regular monitoring. It is acknowledged, that the patient is using 2 short acting pain medications, and receiving refills on schedule to opiates. This is not generally recommended, is absolutely precluded by guidelines. As such, the currently requested Norco is medically necessary.

**Oxycodone 10mg #60 with 1 refill:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

**Decision rationale:** Regarding the request for Oxycodone, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's function and pain with no side effects or aberrant use, and the patient is noted to undergo regular monitoring. It is acknowledged, that the patient is using 2 short acting pain medications, and receiving refills on schedule to opiates. This is not generally recommended, is absolutely precluded by guidelines. As such, the currently requested Oxycodone is medically necessary.