

<b>Case Number:</b>	CM14-0143963		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	07/25/2008
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	08/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/05/2014

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 is a 59-year-old female with a 7/25/08 date of injury. The mechanism of injury was not noted. According to a progress report dated 8/15/14, the patient complained of right sided neck pain and bilateral low back pain. The pain was aching, dull, stabbing, and throbbing. The pain was alleviated by lying down. Objective findings: tenderness over cervical and lumbar paraspinal muscles overlying the facet joints on both sides and trigger points noted over upper and lower paraspinal muscles, limited ROM (range of motion) of shoulders, cervical and lumbar ROM normal. Diagnostic impression: chronic pain, cervical radiculitis, lumbosacral radiculitis, lumbar spondylosis, shoulder pain, duodenal ulcer disease. Treatment to date: medication management, activity modification. A UR decision dated 8/27/14 modified the requests for Hydrocodone/APAP 10/325mg 30 tablets with 2 refills to 15 tablets with zero refills, Fentanyl 75mcg/hr from 15 patches to 7 patches, and Tizanidine 4mg from 90 tablets with 5 refills to 45 tablets with zero refills for weaning purposes. A specific rationale was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone 10mg acetaminophen 325mg #30 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In the reports reviewed, there is no documentation of significant pain reduction or improved activities of daily living. In addition, there is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, urine drug screen, or CURES monitoring. Therefore, the request for Hydrocodone 10mg Acetaminophen 325mg, #30 with 2 refills was not medically necessary.

**Fentanyl 75mg/hr transdermal patch, #15:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 45.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means, but is not recommended as a first-line therapy. There is no documentation that the patient has failed a first-line oral medication for continuous analgesia. In addition, there is no documentation of significant pain reduction or improved activities of daily living. Furthermore, there is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, urine drug screen, or CURES monitoring. Therefore, the request for Fentanyl 75mcg/hr patch, #15 was not medically necessary.

**Tizanidine 4mg, #90 with 5 refills:** Upheld

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

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

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines state that Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity and off label use for low back pain. In addition, MTUS also states that muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP (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. According to the records reviewed, this patient has been on Tizanidine since at least 5/24/13, if not earlier. Guidelines do not support the long-term use of muscle relaxants. In addition, there is no documentation that the patient has had an acute exacerbation to her pain. Therefore, the request for Tizanidine 4mg, #90 with 5 refills was not medically necessary.