

<b>Case Number:</b>	CM14-0097803		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	08/10/2000
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	06/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Ohio and Texas. 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:

The injured worker is a 51-year-old female who reported an injury on 08/10/2000. The mechanism of injury was not noted within the review. The diagnosis was noted to be left cervical facet pain and right cervical facet pain. Prior treatments were noted to be medications, injections, and radiofrequency ablation. A clinical evaluation on 02/04/2014 noted the injured worker had subjective complaints of right sided neck pain and headaches. She stated cervical pain improved 65% post radiofrequency but worker's comp denied request for right cervical pain. In addition, she had achiness in her right arm, numbness and tingling in the right 3rd, 4th, and 5th fingers. The examination noted tenderness of the cervical facet column and right upper trapezius. There was also pain over the left cervical with range of motion. The treatment plan was for medications and a followup appointment. The rationale for the request was noted within the clinical documentation dated 02/04/2014. The Request for Authorization forms were provided and dated 01/09/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Prescriptions for Oxycontin 30mg 1 tablet TID qty:90 with no 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 On-Going Management Page(s): 78.

**Decision rationale:** The request for 1 Prescriptions for Oxycontin 30mg 1 tablet TID qty:90 with no refill is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines provide 4 domains that are relevant for ongoing monitoring of chronic pain patients on opioids. These include pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The clinical documentation should include pain relief, functional status, appropriate medication use, and side effects. The documentation submitted for review fails to provide an adequate pain assessment. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Therefore, the request for 1 Prescriptions for Oxycontin 30mg 1 tablet TID qty:90 with no refill is not medically necessary.

**1 Prescriptions for Percocet 10/325mg 1-2 tablets every 4-6 hours PRN qty: 210 with no 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 On-Going Management Page(s): 78.

**Decision rationale:** The request for 1 Prescriptions for Percocet 10/325mg 1-2 tablets every 4-6 hours PRN qty: 210 with no refill is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines provide 4 domains that are relevant for ongoing monitoring of chronic pain patients on opioids. These include pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The clinical documentation should include pain relief, functional status, appropriate medication use, and side effects. The documentation submitted for review fails to provide an adequate pain assessment. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The request for 1 Prescriptions for Percocet 10/325mg 1-2 tablets every 4-6 hours PRN qty: 210 with no refill is not medically necessary.

**1 Prescriptions for Tizanidine 4mg 1-2 tablets at HS PRN qty: 60 with no 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 spasticity/Antispasmodic Page(s): 66.

**Decision rationale:** The request for 1 Prescriptions for Tizanidine 4mg 1-2 tablets at HS PRN qty: 60 with no refill is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommend tizanidine as a centrally acting adrenergic agonist that is FDA approved for the management of spasticity; unlabeled use for low back pain. It may be beneficial as an adjunct treatment for fibromyalgia. Liver function tests should be monitored at baseline, 1, 3, and 6 months. This is due to side effects of hepatotoxicity. The documentation submitted for review does not indicate spasticity. In addition, it does not indicate and supply values for liver function tests. Therefore, the request for 1 Prescriptions for Tizanidine 4mg 1-2 tablets at HS PRN qty: 60 with no refill is not medically necessary.