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| <b>Case Number:</b>   | CM15-0013711 |                              |            |
| <b>Date Assigned:</b> | 02/02/2015   | <b>Date of Injury:</b>       | 02/14/2003 |
| <b>Decision Date:</b> | 03/24/2015   | <b>UR Denial Date:</b>       | 01/19/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/23/2015 |

### 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 a 35 year old female who sustained an industrial injury on 02/14/2003. She has back and neck pain. Diagnoses include cervical disc degeneration, sprain of the shoulder and arm, and sprain of the neck. Treatment to date has included medications, home exercise program, and epidural steroid injections. A physician progress note dated 12/23/2014 documents the injured worker still has neck and back pain, and frequent numbness in the left arm and top of the left hand. She has spasms and tenderness in the cervical spine in the paracervical region and the left trapezius. Spurling's negative bilateral upper extremities and Hoffman's is negative in the bilateral upper extremities. Sensation is diminished in the left upper arm and lateral dorsal left forearm. Treatment requested is for Norco 10/325mg #120, and 1 Prescription of Zanaflex 4mg. On 01/19/2015 Utilization Review modified the request for Norco 10/325mg, # 120 to Norco 10/325mg, # 54, and cited was California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines. On 01/19/2015 Utilization Review non-certified the request for Zanaflex 4mg, and cited was California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Prescription of Norco 10/325mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

**Decision rationale:** With regard to this request, the California Chronic Pain Medical Treatment Guidelines state the following about on-going management with opioids: "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: 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." Guidelines further recommend discontinuing opioids if there is no documentation of improvement in function and reduction in pain.' In the progress reports available for review, the requesting provider did not adequately document monitoring of the four domains. Improvement in function was not clearly outlined. The MTUS defines this as a clinical significant improvement in activities of daily living or a reduction in work restrictions. The patient is noted to be on temporary total disability and there was no documented change in work status. A progress note from 5/5/14 date of service did not document the functional areas of improvement in the subjective section of the progress note. Based on the lack of documentation, medical necessity of this request cannot be established at this time. Although this opioid is not medically necessary at this time, it should not be abruptly halted, and the requesting provider should start a weaning schedule as he or she sees fit or supply the requisite monitoring documentation to continue this medication.

**1 Prescription of Zanaflex 4mg #150:** Upheld

**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:** 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 appropriate liver function testing, as recommended by guidelines. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. This patient has been on tizanidine long-term and there is documentation that it has been for at least since 4/15/14. This worker has long standing chronic

pain. In the absence of such documentation, the currently requested tizanidine (Zanaflex), is not medically necessary.