

<b>Case Number:</b>	CM15-0079403		
<b>Date Assigned:</b>	04/30/2015	<b>Date of Injury:</b>	02/06/2013
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	03/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2015

### 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: New York, Tennessee  
 Certification(s)/Specialty: Emergency Medicine

### 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 27 year old male who sustained an industrial injury on 02/06/2013. Diagnoses include lumbar degenerative disc disease, lumbar radiculopathy, sciatica, and left lower extremity weakness. Treatment to date has included diagnostic studies, medications, physical therapy, chiropractic sessions, ice and heat, and epidural steroid injection. A physician progress note dated 03/16/2015 documents the injured worker complains of lower back pain and bilateral lower extremity radiculopathy. He has limited range of motion in flexion to 45 degrees, extension 0 degrees, and lateral flexion to 15 degrees. Lumbar spine reveals tenderness to palpation and spasms noted at the L4-5 and L5-S1 left greater than right paraspinals, piriformil and sacroiliac joints. There is positive straight leg raise on the left. The treatment plan is for medications, appeal of the denial of cognitive behavioral therapy x 9 sessions, and continuation of physical therapy. Treatment requested is for Functional Capacity Evaluation, Retrospective Norco 10/325 mg #90 (3-16-15), Retrospective Omeprazole 20 mg #60 3-16-15, Retrospective Zanaflex 4 mg #90 3/16/15, and Retrospective Zorvolex 35 mg #60 3-16-15.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional capacity evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 137-138. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), fitness for duty chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Fitness for Duty: Functional Capacity Evaluations.

**Decision rationale:** Both job-specific and comprehensive FCEs can be valuable tools in clinical decision-making for the injured worker; however, FCE is an extremely complex and multifaceted process. Little is known about the reliability and validity of these tests and more research is needed. Guidelines for performing an FCE: If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. Consider an FCE if: (1) Case management is hampered by complex issues such as: Prior unsuccessful RTW attempts. Conflicting medical reporting on precautions and/or fitness for modified job. Injuries that require detailed exploration of a worker's abilities (2) Timing is appropriate: Close or at MMI/all key medical reports secured. Additional/secondary conditions clarified. Do not proceed with an FCE if the sole purpose is to determine a worker's effort or compliance. The worker has returned to work and an ergonomic assessment has not been arranged. In this case, there is no documentation that the patient has failed attempts to return to work or that he is close to MMI. FCE is not indicated. The request is not medically necessary.

**Retrospective Norco 10/325 mg #90 (3-16-15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 11, 74-96.

**Decision rationale:** Norco is the compounded medication containing hydrocodone and acetaminophen. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain or function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDS have failed. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. Acetaminophen is

recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case, the patient has been receiving Norco since at least December 2014 and has not obtained analgesia. In addition, there is no documentation that the patient has signed an opioid contract or is participating in urine drug testing. Criteria for long-term opioid use have not been met. The request is not medically necessary.

**Retrospective Zanaflex 4 mg #90 3/16/15: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 63, 65.

**Decision rationale:** Zanaflex is the muscle relaxant tizanidine. It acts centrally as an alpha2-adrenergic agonist that is FDA approved for management of spasticity. Side effects include somnolence, dizziness, dry mouth, hypotension, weakness, and hepatot non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment (less than two weeks) of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP 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. Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. In this case, the patient has been using Zanaflex since at least December 2014. The duration of treatment surpasses the recommended short-term duration of two weeks. The request is not medically necessary.

**Retrospective Zorvolex 35 mg #60 3-16-15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain, diclofenac.

**Decision rationale:** Zorvolex is the non-steroidal anti-inflammatory drug (NSAID) diclofenac. Chronic Medical Treatment Guidelines state that anti-inflammatory drugs are the traditional first line of treatment, but long-term use may not be warranted. For osteoarthritis it was recommended that the lowest dose for the shortest length of time be used. It was not shown to be more effective

than acetaminophen, and had more adverse side effects. Adverse effects for GI toxicity and renal function have been reported. Diclofenac is not recommended as first line due to increased risk profile. A large systematic review of available evidence on NSAIDs confirms that diclofenac, a widely used NSAID, poses an equivalent risk of cardiovascular events to patients as did rofecoxib (Vioxx). This is a significant issue and doctors should avoid diclofenac because it increases the risk by about 40%. Diclofenac is not recommended. The request is not medically necessary.

**Retrospective Omeprazole 20 mg #60 3-16-15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 68.

**Decision rationale:** Omeprazole is a proton pump inhibitor (PPI). PPI's are used in the treatment of peptic ulcer disease and may be prescribed in patients who are using non-steroidal anti-inflammatory drugs and are at high risk for gastrointestinal events. Risk factors for high-risk events are age greater than 65, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The patient in this case was using NSAID medication, but did not have any of the risk factors for a gastrointestinal event. The request is not medically necessary.