

<b>Case Number:</b>	CM15-0093682		
<b>Date Assigned:</b>	05/20/2015	<b>Date of Injury:</b>	07/17/2014
<b>Decision Date:</b>	06/24/2015	<b>UR Denial Date:</b>	04/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/14/2015

### 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: Texas, California  
 Certification(s)/Specialty: Family Practice

### 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 49 year old male patient who sustained an industrial injury on 7/17/14. The diagnoses include chronic sprain/strain of the lumbar spine and discogenic low back pain. He sustained the injury due to fell from 3 feet height. Per the doctor's note dated 4/1/15, he had complaints of lower back pain with radiation to the right lower extremity. His pain level was noted as 4-5/10 with medication and 10/10 without medication. Physical examination revealed moderately obese, slow and guarded gait, range of motion of the lumbar spine- flexion 60 and extension 20 degrees, tenderness to palpation to the lumbar spinous process and right paraspinal muscle area, 4/5 strength and decreased sensation in right lower extremity. The medications list includes mobic, motrin, norco, trazodone and zanaflex. He has history of sleep disturbances. He has had lumbar MRI on 8/11/14 which revealed central spinal and neural foraminal stonosis at multiple levels. He has had physical therapy visits for this injury. He has had urine drug screen on 1/21/15 which was inconsistent for hydrocodone. The plan of care was for medication prescriptions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 75, 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-80.

**Decision rationale:** Request: Norco 10/325mg #180. Norco contains hydrocodone and acetaminophen. Hydrocodone is an opioid analgesic. According to the cited guidelines, "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." The records provided do not specify that that patient has set goals regarding the use of opioid analgesic. The treatment failure with non-opioid analgesics is not specified in the records provided. Other criteria for ongoing management of opioids are: "The lowest possible dose should be prescribed to improve pain and function. Continuing review of overall situation with regard to nonopioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects...Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs." The records provided do not provide a documentation of response in regards to pain control and objective functional improvement to opioid analgesic for this patient. The continued review of the overall situation with regard to non-opioid means of pain control is not documented in the records provided. As recommended by the cited guidelines a documentation of pain relief, functional status, appropriate medication use, and side effects should be maintained for ongoing management of opioid analgesic, these are not specified in the records provided. He has had urine drug screen on 1/21/15 which was inconsistent for hydrocodone. This patient does not meet criteria for ongoing continued use of opioids analgesic. The medical necessity of Norco 10/325mg, #180 is not established for this patient.

**Zanaflex 4mg #60:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY/ANTISPASMODIC DRUGS: Tizanidine (Zanaflex) Page(s): 66.

**Decision rationale:** Request: Zanaflex 4mg #60. According to MTUS guidelines "Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. May also provide benefit as an adjunct treatment for fibromyalgia." The patient has chronic lower back pain with radiation to the right lower extremity. The patient has significant objective abnormalities on the musculoskeletal physical examination- range of motion of the lumbar spine- flexion 60 and extension 20 degrees, tenderness to palpation to the lumbar spinous process and right paraspinal muscle area, 4/5 strength and decreased sensation in right lower extremity. The

patient has abnormal objective findings on physical examination. The patient has had diagnostic studies with abnormal findings. Tizanidine is recommended for chronic myofascial pain. The request of Zanaflex 4mg #60 is deemed medically appropriate and necessary for this patient.

**Trazodone 50mg #60: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Insomnia treatment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Pain (updated 06/15/15) Insomnia treatment Selective serotonin reuptake inhibitors (SSRIs), Sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine).

**Decision rationale:** Request: Trazodone 50mg #60. Trazodone is tetra cyclic antidepressant. According to the CA MTUS chronic pain guidelines, antidepressant is "Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated.)" In addition, per the cited guidelines "Trazodone is one of the most commonly prescribed agents for insomnia." Per the records provided, he had complaints of chronic low back pain with right lower extremity radiculopathy symptoms. He is also having insomnia due to chronic pain. Trazodone is a first line agent in this clinical situation. The request of Trazodone 50mg #60 is medically appropriate and necessary for this patient.