

Case Number:	CM13-0029933		
Date Assigned:	03/19/2014	Date of Injury:	06/01/2001
Decision Date:	04/23/2014	UR Denial Date:	09/12/2013
Priority:	Standard	Application Received:	09/25/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician 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 Physician 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:

According to the records made available for review, this is a 59-year-old male with a 6/1/01 date of injury, and status post right shoulder arthroplasty and IDET 2002. At the time (9/12/13) of request for authorization for Functional Restoration Program (FRP) evaluation, one (1) prescription of Ultracet 37.5/325MG, #90, with one (1) refill, and one (1) prescription of Zanaflex 4MG, there is documentation of subjective (severe low back pain with deep, aching, and stabbing sensation on the low back radiation in to bilateral posterior thighs, limited bending, walking, and standing more than 20-30 minutes; moderate to severe sleep disturbance; mild depression or anxiety caused by chronic pain; decreased in functional abilities) and objective (mild distress, anxious, depressed, restricted lumbar spine ROM due to pain, and normal muscle tone) findings, current diagnoses (lumbar/lumbosacral disc degeneration, and myofascial pain syndrome), and treatment to date (PT, gym, activity modification, TENS, and medications (including ongoing use of Zanaflex)). The 8/26/13 medical report identified that the patient has noted some functional benefit from Norco in the past, however, he does not ever remember being tried on Ultracet; the patient is a surgical candidate, but patient defers surgery at this time. Regarding the requested Functional Restoration Program (FRP) evaluation, there is no documentation that the patient is not a candidate where surgery or other treatments would clearly be warranted and that the patient exhibits motivation to change. Regarding the requested one (1) prescription of Ultracet 37.5/325MG, #90, with one (1) refill, there is no documentation that the prescriptions are from a single Final Determination Letter for IMR Case Number [REDACTED] [REDACTED] 3 practitioner and are taken as directed; that the lowest possible dose is being prescribed; and that there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Regarding the requested one (1) prescription of Zanaflex 4MG, there is no documentation of spasticity, acute low back pain or an acute

exacerbation of chronic low back pain, and an intention for a short-term treatment; functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. IMR DECISION(S)

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE (1) FUNCTIONAL RESTORATION PROGRAM (FRP) EVALUATION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section Functional Rest.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section Chronic Pain Programs (functional restoration).

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identify documentation that previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; the employee has a significant loss of ability to function independently resulting from the chronic pain; the employee is not a candidate where surgery or other treatments would clearly be warranted; and the employee exhibits motivation to change, as criteria necessary to support the medical necessity of chronic pain program evaluation. Within the medical information available for review, there is documentation of diagnoses of lumbar/lumbosacral disc degeneration, and myofascial pain syndrome. In addition, there is documentation that previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; that the employee has a significant loss of ability to function independently resulting from the chronic pain. However, given documentation that the employee is a surgical candidate but defers surgery at this time, there is no documentation that the employee is not a candidate where surgery or other treatments would clearly be warranted. In addition, there is no documentation that the employee exhibits motivation to change. Therefore, based on guidelines and a review of the evidence, the request for Functional Restoration Program (FRP) evaluation is not medically necessary.

ONE (1) PRESCRIPTION OF ULTRACET 37.5/325MG, #90, WITH ONE (1) REFILL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section Opioids for Chr.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section Opioids Page(s): 74-80.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to

support the medical necessity of opioids. Within the medical information available for review, there is documentation of diagnoses of lumbar/lumbosacral disc degeneration, and myofascial pain syndrome. In addition, there is documentation that the employee has not had a trial of Ultracet before. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; that the lowest possible dose is being prescribed; and that there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Therefore, based on guidelines and a review of the evidence, the request for one (1) prescription of Ultracet 37.5/325MG, #90, with one (1) refill is not medically necessary.

ONE (1) PRESCRIPTION OF ZANAFLEX 4MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section Antispasticity/Antispasmodic Drugs (Tizanidin. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Pain, Muscle Relaxants (for pain)

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identify documentation of spasticity, as criteria necessary to support the medical necessity of Tizanidine. The ODG guidelines identify that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. In addition, MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar/lumbosacral disc degeneration, and Final Determination Letter for IMR Case Number [REDACTED] 5 myofascial pain syndrome. In addition, there is documentation of ongoing use of Zanaflex. However, there is no documentation of spasticity, acute low back pain or an acute exacerbation of chronic low back pain, and an intention for a short-term treatment. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of Zanaflex use to date. Therefore, based on guidelines and a review of the evidence, the request for one (1) prescription of Zanaflex 4MG is not medically necessary. [REDACTED]

[REDACTED]