

Case Number:	CM14-0024686		
Date Assigned:	06/11/2014	Date of Injury:	08/12/2011
Decision Date:	08/04/2014	UR Denial Date:	02/21/2014
Priority:	Standard	Application Received:	02/26/2014

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 Anesthesiology, has a subspecialty in Pain 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 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:

According to the records made available for review, this is a 49-year-old female with a 8/12/11 date of injury. At the time of the request for authorization, there is documentation of subjective complaints of lower back pain, posterior neck pain, upper back pain, mid back pain, right shoulder pain, and right wrist pain, and objective findings of pain with decreased range of motion of the cervical spine, lumbar spine, and shoulder. Current diagnoses include cervicalgia, thoracalgia, brachial neuritis or radiculitis, sciatica, and lumbar sprain or strain, and treatment to date has been medications (including Norco, Ultram, and Zanaflex since at least 2/28/13), acupuncture, and ESWT.

IMR ISSUES, DECISIONS AND RATIONALES

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

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 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. 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 cervicalgia, thoracalgia, brachial neuritis or radiculitis, sciatica, and lumbar sprain or strain. In addition, there is documentation of ongoing treatment with Norco. However, there is no 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. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions or an increase in activity tolerance as a result of Norco use to date. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.

ULTRAM 52MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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. 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 cervicalgia, thoracalgia, brachial neuritis or radiculitis, sciatica, and lumbar sprain or strain. In addition, there is documentation of ongoing treatment with Ultram. However, there is no 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. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions or an increase in activity tolerance as a result of Ultram use to date. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.

ZANAFLEX 4MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of spasticity, as criteria necessary to support the medical necessity of Tizanadine. 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. The Official Disability Guidelines state 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. Within the medical information available for review, there is documentation of diagnoses of cervicalgia, thoracalgia, brachial neuritis or radiculitis, sciatica, and lumbar sprain or strain. In addition, there is documentation of ongoing treatment of Zanaflex since at least 2/28/13. However, there is no documentation of spasticity. In addition, given documentation of ongoing treatment since at least 2/28/13, there is no documentation that Zanaflex is being used as a second line option for short-term (less than two weeks) treatment. Furthermore, 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 as a result of Zanaflex use to date. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.