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| Case Number: | CM15-0063125 | | |
| Date Assigned: | 04/08/2015 | Date of Injury: | 08/05/1976 |
| Decision Date: | 05/08/2015 | UR Denial Date: | 03/02/2015 |
| Priority: | Standard | Application Received: | 04/02/2015 |

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 62-year-old female who sustained an industrial injury on 08/05/1976. Current diagnosis includes lumbar degenerative joint disease. Previous treatments included medication management, home exercises, and myofascial release therapy. Previous diagnostic studies included an MRI. Report dated 02/10/2015 noted that the injured worker presented with complaints that included back pain, severe cramps with radiation down the right hip and leg. Pain level was not included. Physical examination was positive for abnormal findings. The treatment plan included resume medications noting that they keep her functional, re-evaluation in 2-3 months, and start some myofascial release therapy visits. Requested treatments include Norco, Zanaflex, and 8 myofascial release therapy visits. A progress report dated March 31, 2015 indicates that the patient occasionally takes Norco for pain which results in 50% reduction in pain and 50% improvement with activities of daily living. The patient is doing a home exercise program and utilizing work modifications. The patient uses Zanaflex for muscle spasms. The note indicates that a narcotic contract is present and urine drug screens have been appropriate.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list; Weaning of Medications Page(s): 91; 78-80; 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Norco, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's function and pain with no side effects or aberrant use, and the patient is noted to undergo regular monitoring. In light of the above, the currently requested Norco is medically necessary.

Zanaflex 2mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63, 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

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 of a specific analgesic benefit or objective functional improvement as a direct result of the tizanidine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, it does not appear that there has been appropriate liver function testing, as recommended by guidelines. In the absence of such documentation, the currently requested tizanidine (Zanaflex), is not medically necessary.

8 myofascial release therapy visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 ? 9792.26 MTUS (Effective July 18, 2009) Page(s): 60 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Massage Therapy.

Decision rationale: Regarding the request for myofascial release therapy, Chronic Pain Medical Treatment Guidelines state the massage therapy is recommended as an option. They go on to

state the treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4 to 6 visits in most cases. Within the documentation available for review, there is no indication as to whether the patient has previously undergone myofascial release therapy. Additionally, there is no indication that the currently requested myofascial release therapy will be used as an adjunct to other recommended treatment modalities. Furthermore, it is unclear exactly what objective treatment goals are hoping to be addressed with the currently requested myofascial release therapy. Finally, the current request exceeds the maximum number recommended by guidelines. As such, the currently requested myofascial release therapy is not medically necessary.