

<b>Case Number:</b>	CM13-0031058		
<b>Date Assigned:</b>	12/04/2013	<b>Date of Injury:</b>	05/10/2000
<b>Decision Date:</b>	02/04/2014	<b>UR Denial Date:</b>	09/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in New York and Texas. 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:

The patient is a 41-year-old female who sustained a work-related injury on 05/10/2000. The patient's diagnoses include osteoarthritis, disc degeneration, and disc displacement without myelopathy. Subjectively, the patient reported complaints of low back, right hip, left knee, and left ankle pain. Physical examination revealed edema, tenderness, and a positive Phalen's bilaterally. The treatment plan included continuation of physical therapy and medication refills to include Vicodin, Zanaflex, and Lidoderm.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Evaluation and Treatment:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** ACOEM guidelines state that "referral may be appropriate if the practitioner is uncomfortable with the line of inquiry outlined above, with treating a particular cause of delayed recovery (such as substance abuse), or has difficulty obtaining information or agreement

to a treatment plan." The clinical information submitted for review does not provide a rationale as to why the patient requires an evaluation and treatment. Given the lack of specific documentation submitted for review, the request is not supported. As such, the request for evaluation and treatment is non-certified.

**PHYSICAL THERAPY (PT)/Aquatic Therapy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy, Physical Medicine, Page(s): 22, 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine; Aquatic Therapy Page(s): 98-99; 22.

**Decision rationale:** CA MTUS guidelines state that "aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable." Additionally, CA MTUS Guidelines for physical medicine state that "active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort, and that patients are instructed in and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." The clinical information submitted for review indicates the patient has undergone prior physical therapy. There is no objective documentation of functional improvement or pain reduction with prior physical therapy. Additionally, there is no physical therapy documentation provided for review to determine the patient's progress or compliance with prior physical therapy or her home exercise program. As such, the request for physical therapy (PT)/aquatic therapy is non-certified.

**Vicodin 5mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

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

**Decision rationale:** CA MTUS Guidelines recommends the documentation of "4 A's" which consists of "(analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." The clinical information submitted for review indicates the patient has been on the requested medication since at least 12/2012. There is lack of objective documentation of medication efficacy or functional improvement being obtained through the continued use of the requested medication. Additionally, the request lacks a quantity of the requested medication. Given the above, the request is not supported. As such, the request for Vicodin 5 mg is non-certified.

**Zanaflex 2mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), Antispasticity/Antispasmodic Drugs Pa.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY/ANTISPASMODIC DRUGS: Tizanidine (Zanaflex, generic available) Page(s): 63 and 66.

**Decision rationale:** CA MTUS guidelines state that "Tizanidine (Zanaflex, generic available) is a second line treatment approved for management of spasticity." The clinical information submitted for review lacks documentation that the patient has attempted and failed first-line treatment. Additionally, physical examination findings were negative for spasms. Given there is no evidence to support the use of the requested medication, the request cannot be validated. As such, the request for Zanaflex 2 mg is non-certified.

**Lidoderm Patch:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57.

**Decision rationale:** CA MTUS guidelines state that Lidoderm "is not a first-line treatment, is only FDA approved for post-herpetic neuralgia, and further research is needed to recommend it for chronic neuropathic pain disorders other than post-herpetic neuralgia." The clinical information submitted for review lacks documentation that the patient has attempted and failed first-line treatment. Additionally, there is no objective documentation of evidence to support a neuropathic pathology to warrant the use of the requested medication. Given the above and the lack of guideline recommendations, the request is not supported. As such, the request for Lidoderm patch is non-certified.