

Case Number:	CM13-0032504		
Date Assigned:	12/11/2013	Date of Injury:	08/11/2000
Decision Date:	01/24/2014	UR Denial Date:	09/25/2013
Priority:	Standard	Application Received:	10/08/2013

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 Family Practice, and is licensed to practice in 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 66-year-old male who reported a work-related injury on 08/11/2000. The patient underwent a 2 level cervical fusion in 1989. Cervical spine MRI revealed anterior discectomy and fusion with postsurgical changes at C5-6 and C6-7 and a posterior disc protrusion at C7 and T1 with bilateral foraminal stenosis. The patient complains of neck pain with associated cervicogenic headaches. The patient has also undergone a thoracic myoligamentous injury. The patient has undergone multiple facet rhizotomies and trigger point injections. A request has been made for chiropractic 2x4, physical therapy 2x4, Flexrid 7.5 mg #60, Lunesta 3 mg #30, Nuvigil 250 mg #30, and Lidoderm patch #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 2 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

Decision rationale: The Physician Reviewer's decision rationale: The clinical note dated 11/14/2013 stated the patient had been experiencing increased neck pain with associated cervicogenic headaches. He rated his pain on this date as 6/10. The patient was requesting

trigger point injections to his neck since it had consistently provided a good 50% relief lasting 2 weeks. It was noted that the patient recently completed chiropractic treatment. A progress report from the chiropractor noted the patient had improved mobility in his thoracolumbar range of motion as well as improvement in the level of pain and was recommending an additional treatment for 6 more weeks. Examination of the thoracic spine revealed moderate tenderness to palpation in the upper mid thoracic spine about the level of T7. Examination of the cervical spine revealed pain to palpation along the cervical musculature and the patient had limited range of motion with flexion to about 3 fingerbreadths from the sternum and extension limited to about 10 degrees. California Chronic Pain Medical Treatment Guidelines indicate that the intended goal or effect of manual therapy is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in a patient's therapeutic exercise program and return the patient to productive activities. There is a lack of documentation submitted noting the patient's functional improvement which could be objectively measured due to his prior chiropractic treatments. It was unclear per submitted documentation how many chiropractic visits the patient has completed to this date. California Medical Treatment Guidelines for chronic pain recommend a trial of 6 visits over 2 weeks and with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks. Given the above, the request for chiropractic 2x4 is non-certified.

Physical therapy 2 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: The Physician Reviewer's decision rationale: Recent clinical documentation submitted for review stated the patient had limited range of motion with flexion in the cervical area. California Medical Treatment Guidelines for chronic pain indicate 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. Guidelines recommend 9 to 10 visits of physical therapy over 8 weeks for myalgia and myositis. There was a lack of documentation submitted for review stating when the patient had last completed physical therapy sessions. There was also a lack of significant functional deficits to warrant formal physical therapy visits versus a home exercise program for the patient. As such, the request for physical therapy 2x4 is non-certified.

Flexrid 7.5 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants for pain .

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: The Physician Reviewer's decision rationale: Recent clinical documentation stated that the patient was still feeling effects following his recent facet rhizotomy performed at T7, T8, and T9. The patient was noted to have been able to cut back on the amount of Norco he took from 6 tablets a day to 3 tablets a day and was able to sleep better at night. It was also noted since the procedure the patient had been experiencing increased neck pain and was requesting trigger point injections. The patient's Zanaflex was discontinued since it may have been a possible contributor to his dry mouth and he was changed to Robaxin which had been effective in managing his muscle spasms. It was noted that the insurance carrier was denying authorization of refills. A request was made for Fexmid 7.5 mg #60. Fexmid, or cyclobenzaprine is recommended as an option, using a short course of therapy per California Medical Treatment Guidelines for chronic pain. Guidelines indicate that treatment should be brief and the addition of cyclobenzaprine to other agents is not recommended. Therefore, the request for Fexmid 7.5 mg #60 is non-certified.

Lunesta 3 mg #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Insomnia treatment

Decision rationale: The Physician Reviewer's decision rationale: Recent clinical documentation stated that due to the patient's chronic pain and poor sleep pattern as well as chronic opioid use, the patient reported significant daytime somnolence which he felt the Nuvigil enabled him to be active during the day with improved alertness and activity tolerance. Official Disability Guidelines indicate that pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance. There was a lack of documentation stating the patient had insomnia. Guidelines state the specific component of insomnia should be addressed to include sleep onset, sleep maintenance, sleep quality and next day functioning. There was no documentation stating the specific components of the patient's insomnia per guideline criteria. Guidelines state that long-term use of Lunesta may result in further functional impairment, increase pain and depression levels. As such, the request for Lunesta 3 mg #30 is non-certified.

Nuvigil 250 mg #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Armodafinil (Nuvigil).

Decision rationale: The Physician Reviewer's decision rationale: Recent clinical documentation stated the patient reported significant daytime somnolence which was due to his chronic pain, poor sleep pattern as well as chronic opioid use. The patient stated the Nuvigil enabled him to be active during the day with improved alertness and activity tolerance. Official Disability Guidelines indicate that Nuvigil is not recommended solely to counteract sedation effects of narcotics until after first considering reducing excessive narcotic prescribing. Armodafinil is used to treat excessive sleepiness caused by narcolepsy or shift work sleep disorder. The clinical documentation submitted does not state the patient has a diagnosis of narcolepsy, shift work sleep disorder or sleep apnea that would support the medical necessity of Nuvigil. Therefore, the request for Nuvigil 250 mg #30 is non-certified.

Lidoderm patch #60: Upheld

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

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

Decision rationale: The Physician Reviewer's decision rationale: Recent clinical documentation submitted for review stated that the Lidoderm worked very well for the patient for his local thoracic pain. It was noted the patient put 2 patches on a day and found it increased his activity level and cut back his need for oral medications. California Chronic Pain Medical Treatment Guidelines indicate that topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy to include tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica. Lidoderm patch is not a first line treatment and is only FDA approved for postherpetic neuralgia. Guidelines further state that further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. The clinical documentation submitted for review does not give evidence of a trial of first line therapy for the patient. Given the above, the request for Lidoderm patch #60 is non-certified.