

Case Number:	CM13-0051920		
Date Assigned:	12/27/2013	Date of Injury:	03/19/2004
Decision Date:	09/16/2014	UR Denial Date:	11/06/2013
Priority:	Standard	Application Received:	11/15/2013

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 Family 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:

This is a 56 year old female who reported an industrial injury to the lower back on 3/19/2004, over ten years ago, attributed to the performance of her job tasks. The patient complains of neck pain; left shoulder pain; myofascial pain; lower back pain; BUE pain and BLE pain. The patient is s/p left shoulder surgery during 2006; s/p right CTR in 2007; left CTR in 2008. The patient is prescribed Cymbalta; Tizanidine; Naproxen; and Norco. The objective findings on examination included sensory deficits to the bilateral calves; DTRs symmetrical; EHL with minimal weakness on the BLE; no sensory or motor deficits to the BUE. The MRI dated 9/16/2013 demonstrated evidence of multilevel degenerative disc disease. The patient was prescribed 2x6 sessions of PT directed to the lumbar spine; Naproxen; and Tizanidine.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TWO TIMES A WEEK FOR SIX WEEKS FOR THE LOW BACK AND LOWER EXTREMITY PAIN: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-300, Chronic Pain Treatment Guidelines physical medicine Page(s): 97-98.

Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter-PT; back chapter-PT.

Decision rationale: The request is for authorization of 2x6 additional sessions of PT to the back 10 years after the DOI exceeds the number of sessions of PT recommended by the CA MTUS and the time period recommended for rehabilitation. The evaluation of the patient documented no objective findings on examination to support the medical necessity of physical therapy 10 years after the cited DOI with no documented weakness or muscle atrophy as opposed to a self-directed HEP. There are no objective findings to support the medical necessity of 2x6 sessions of physical therapy for the rehabilitation of the patient over the number recommended by evidence-based guidelines. The patient is documented with no signs of weakness, no significant reduction of ROM, or muscle atrophy. There is no demonstrated medical necessity for the prescribed PT to the back 10 years after the DOI and subsequent to the completion of a FRP. The patient is not documented to be in HEP. There is no objective evidence provided by the provider to support the medical necessity of the requested 2x6 sessions of PT over a self-directed home exercise program. The CA MTUS recommends ten (10) sessions of physical therapy over 8 weeks for the lumbar spine rehabilitation subsequent to lumbar strain/sprain and lumbar spine DDD with integration into HEP. The provider did not provide any current objective findings to support the medical necessity of additional PT beyond the number recommended by evidence based guidelines. The request is not medically necessary and appropriate.

NAPROSYN 550MG, TWICE A DAY #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-inflammatory medications Page(s): 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter--medications for chronic pain and NSAIDS.

Decision rationale: The use of Anaprox/Naproxen 550 mg is consistent with the currently accepted guidelines and the general practice of medicine for musculoskeletal strains and injuries; however, there is no evidence of functional improvement or benefit from this NSAID. There is no evidence that OTC NSAIDs would not be appropriate for similar use for this patient. The prescription of Naproxen is not supported with appropriate objective evidence as opposed to the NSAIDs available OTC. The prescription of Naproxen should be discontinued in favor of OTC NSAIDs. There is no provided evidence that the available OTC NSAIDs were ineffective for the treatment of inflammation. The prescription for naproxen 550 mg #60 is not medically necessary and appropriate.

TIZANIDINE 4MG, TWICE A DAY AS NEEDED, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47,128,Chronic Pain Treatment Guidelines muscle relaxants for pain Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-medications for chronic pain; muscle relaxants; cyclobenzaprine.

Decision rationale: The patient has been prescribed muscle relaxers for chronic pain on a routine basis as there are no muscle spasms documented by the requesting provider while treating chronic thoracic spine sprain/strain. The patient is prescribed Tizanidine 4 mg #60 on a routine basis routinely for which there is no medical necessity in the treatment of chronic pain. The routine prescription of muscle relaxers for chronic pain is not supported with objective medical evidence and is not recommended by the CA MTUS. The use of the Tizanidine for chronic muscle spasms is not supported by evidence-based medicine; however, an occasional muscle relaxant may be appropriate in a period of flare up or muscle spasm. The prescription for Tizanidine (Zanaflex) is recommended by the CA MTUS or the Official Disability Guidelines for the short-term treatment of muscle spasms but not for chronic treatment. The chronic use of muscle relaxants is not recommended by the CA MTUS, the ACOEM Guidelines, or the Official Disability Guidelines for the treatment of chronic pain. The use of muscle relaxants are recommended to be prescribed only briefly for a short course of treatment and then discontinued. There is no recommendation for Tizanidine as a sleep aid. There is no documented functional improvement with the prescription of Zanaflex. The patient is prescribed Zanaflex for muscle spasms to the lower back. The CA MTUS does recommend Tizanidine for the treatment of chronic pain as a centrally acting adrenergic agonist approved for spasticity but unlabeled or off label use for chronic back pain. The request is not medically necessary and appropriate.