

<b>Case Number:</b>	CM14-0115479		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	03/03/2014
<b>Decision Date:</b>	10/03/2014	<b>UR Denial Date:</b>	07/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2014

### 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 Physical Medicine & Rehabilitation 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:

The patient is a 40 year old female who was injured on 03/03/2014. The mechanism of injury is unknown. Prior treatment history has included physical therapy. Prior medication history included Voltaren, Tizanidine, Lidoderm, and anti-inflammatory. Progress report dated 07/21/2014 documented the patient to report she is doing well with Tizanidine as it helps with her spasm when she is having a flare up. She reported she occasionally has numbness radiating into the back of the left upper arm. On exam, deep tendon reflexes are equal and symmetric in the bilateral upper extremities. Tinel's test is negative at the bilateral ulnar grooves. She is diagnosed with neck pain, cervical radiculitis, and thoracic spine pain. As the patient's physical therapy was denied, the request is now for acupuncture 2 times a week for 4 weeks; Tizanidine and Lidoderm patch. Prior utilization review dated 07/09/2014 states the request for Physical therapy x8 is denied there is not documented functional improvement; Tizanidine is denied as it is not medically necessary; and Lidoderm patch is denied as medical necessity has not been established.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy x8:** 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) Physical Therapy Guidelines- Neck

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

**Decision rationale:** As per CA MTUS guidelines, physical medicine 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. ODG guidelines recommends 9 visits of PT over 8 weeks for intervertebral disc disorders without myelopathy. In this case, the injured worker has already received unknown number of physical therapy visits; however, there is no documentation of any significant improvement in the objective measurements (pain level such as "VAS", range of motion, strength or function) with physical therapy to demonstrate the effectiveness of this modality in this injured worker. There is no evidence of presentation of any new injury / surgical intervention. Moreover, additional PT visits would exceed the guidelines criteria. Furthermore, there is no mention of the patient utilizing an HEP (At this juncture, this patient should be well-versed in an independently applied home exercise program, with which to address residual complaints, and maintain functional levels). Therefore, the request is considered not medically necessary or appropriate in accordance with the guidelines.

**Tizanidine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex, generic available) Page(s): 66.

**Decision rationale:** According to the CA MTUS guidelines, Tizanidine (Zanaflex) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. In this case, there is no documentation of spasticity, (which is different from spasm). There is no documentation of first line therapy for the treatment of spasm in this IW. There is no evidence of any improvement in function with prior use. Therefore, the request is not medically necessary according to the guidelines.

**Lidoderm patch:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch), Topical Analgesics Page(s): 56-57,111-113.

**Decision rationale:** According to the CA MTUS guidelines, Topical Analgesics "Lidocaine" is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). Other indications are considered off-label. There is no documentation of neuropathic pain in this case.

There is no evidence of first line therapy. Hence, the request is not medically necessary according to the guidelines.