

Case Number:	CM14-0130663		
Date Assigned:	08/20/2014	Date of Injury:	07/16/2002
Decision Date:	10/02/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	08/15/2014

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 Internal 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:

The injured worker is a 48-year-old male with a reported date of injury on 07/16/2002. The mechanism of injury was not submitted within the medical records. His diagnoses were noted to include chronic neck and low back pain, chronic headaches, and lateral epicondylitis. His previous treatments were noted to include physical therapy and medications. The progress note dated 07/08/2014 revealed complaints of pain from the back to the left leg that occurred in any position, with walking and standing. The injured worker described the pain as burning and complained of a lot of headaches and reported he did not sleep well at night. The physical examination revealed tenderness to palpation over the cervical and lower back region. The back pain and left leg pain increased with flexion of the back. The range of motion was noted to be flexion to 60 degrees and extension to 20 degrees with increased back pain. There was a positive straight leg raise and reflexes were 1+ symmetric at the biceps, triceps, and brachioradialis. The motor strength was rated 5/5 in the bilateral upper and lower extremities. The Request for Authorization form was not submitted within the medical records. The request was for physical therapy x8 visits for the deconditioning in the trunk muscles, therapeutic exercise, home exercise program, Lyrica 150 mg for neuropathic pain, and Edluar 10 mg #15 for sleep.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy x 8 visits: Upheld

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

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

Decision rationale: The request for Physical therapy times eight visits is not medically necessary. The injured worker has had previous physical therapy sessions. The California Chronic Pain Medical Treatment Guidelines recommend active therapy 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The guidelines recommend for myalgia and myositis 9 to 10 visits over 8 weeks. The injured worker has completed previous physical therapy sessions, but there is a lack of documentation with quantifiable objective functional improvements with previous physical therapy. Therefore, despite the current measurable functional deficits, without quantifiable objective functional improvements and number of previous sessions completed, additional physical therapy is not appropriate at this time. As such, the request is not medically necessary.

Lyrica 150mg #150 with 5 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs, Page(s): 16.

Decision rationale: The request for Lyrica 150mg #150 with 5 refills is not medically necessary. The injured worker has been utilizing Lyrica. The California Chronic Pain Medical Treatment Guidelines recommend anti epilepsy drugs for neuropathic pain (pain due to nerve damage). There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Most randomized controlled trials for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy. There are few randomized controlled trials directed at central pain and none for painful radiculopathy. There is lack of documentation regarding objective functional improvement or efficacy of this medication. Additionally, the request failed to provide the frequency at which this medication is to be utilized. As such, the request is not medically necessary.

Edluar 10mg #15: 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)- TWC Pain Procedure Summary

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

Decision rationale: The Official Disability Guidelines state in late 2009 the FDA approved Edluar (zolpidem tartrate) sublingual tablets, 5 and 10 mg for the treatment of insomnia. This new formulation of the zolpidem (Ambien) tablets does not appear to have any therapeutic benefit over existing generic zolpidem. The guidelines state that zolpidem is a prescription short acting nonbenzodiazepine hypnotic, which is approved for the short term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long term use. They can be habit forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long term. There is a lack of documentation regarding specific sleep quality and duration findings, as well as objective functional improvement from the utilization of this medication. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.