

<b>Case Number:</b>	CM14-0169875		
<b>Date Assigned:</b>	10/20/2014	<b>Date of Injury:</b>	11/29/2011
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	09/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2014

### 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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 49-year-old female with an 11/29/12 date of injury. At the time (6/18/14) of request for authorization for Norco 5/325mg quantity 60.00, Zanaflex 4mg quantity 60.00, Interferential Stimulator purchase with supplies, and Physical Therapy to cervical spine, bilateral upper extremities (sessions) quantity 8.00, there is documentation of subjective (ongoing moderate to severe neck pain with intermittent symptoms of radiating numbness and tingling to the bilateral upper extremities; bilateral shoulder pain with decreased motion and associated weakness; and burning, numbness, and weakness of the mid back, elbows, and wrists) and objective (bilateral shoulder tenderness over the subacromial region, acromioclavicular joints, supraspinatus tendon, periscapular musculature, and trapezius muscles, positive impingement test and cross arm test bilaterally, and decreased bilateral shoulder range of motion; cervical spine tenderness to palpation over the paravertebral muscles with spasms, positive Spurling's test, and decreased cervical range of motion) findings, current diagnoses (cervical spine musculoligamentous sprain/strain with bilateral upper extremity radiculitis, cervical disc protrusions with mild central canal stenosis, cervical multilevel degenerative disc disease, thoracic spine musculoligamentous sprain/strain, bilateral shoulder impingement syndrome, bursitis and periscapular myofascial strain, and bilateral forearm/wrist flexor and extensor tendinitis with dynamic carpal tunnel syndrome), and treatment to date (Zanaflex since at least 1/9/13 and ongoing therapy with Norco with decreased pain levels, improved activities of daily living, and improved participation in home exercise program). 8/21/14 medical report identifies a request to re-initiate physical therapy, continue home exercise program in conjunction with the use of a home interferential muscle stimulation unit, and continue current medication regimen (Norco and Zanaflex). Regarding Norco 5/325mg quantity 60.00, there is no documentation that the prescriptions are from a single practitioner and

are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Regarding Zanaflex 4mg quantity 60.00, there is no documentation of acute exacerbation of chronic pain and short-term (less than two weeks) treatment. Regarding Interferential Stimulator purchase with supplies, there is no documentation of additional recommended treatments (return to work) and limited evidence of improvement on recommended treatments alone (medications).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Norco 5/325mg quantity 60.00: 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 based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical spine musculoligamentous sprain/strain with bilateral upper extremity radiculitis, cervical disc protrusions with mild central canal stenosis, cervical multilevel degenerative disc disease, thoracic spine musculoligamentous sprain/strain, bilateral shoulder impingent syndrome, bursitis and periscapular myofascial strain, and bilateral forearm/wrist flexor and extensor tendinitis with dynamic carpal tunnel syndrome. In addition, given documentation of ongoing treatment with Norco with decreased pain levels, improved activities of daily living, and improved participation in home exercise program, there is documentation of functional benefit or improvement as an increase in activity tolerance as a result of Norco use to date. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Therefore, based on guidelines and a review of the evidence, the request for Norco 5/325mg quantity 60.00 is not medically necessary.

**Zanaflex 4mg quantity 60.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 63.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs (Tizanidine (Zanaflex)) Page(s): 66. Decision based on Non-MTUS Citation MTUS Official Disability Guidelines (ODG) Pain, Muscle Relaxants (for Pain), Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20..

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of spasticity, as criteria necessary to support the medical necessity of Zanaflex. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of cervical spine musculoligamentous sprain/strain with bilateral upper extremity radiculitis, cervical disc protrusions with mild central canal stenosis, cervical multilevel degenerative disc disease, thoracic spine musculoligamentous sprain/strain, bilateral shoulder impingent syndrome, bursitis and periscapular myofascial strain, and bilateral forearm/wrist flexor and extensor tendinitis with dynamic carpal tunnel syndrome. In addition, there is documentation of chronic pain and spasticity. Furthermore, given documentation of ongoing treatment with Zanaflex with decreased pain levels, improved activities of daily living, and improved participation in home exercise program, there is documentation of functional benefit or improvement as an increase in activity tolerance as a result of Zanaflex use to date. However, there is no documentation of acute exacerbation of chronic pain. In addition, given documentation of ongoing treatment with Zanaflex since at least 1/9/13, there is no documentation of short-term (less than two weeks) treatment. Therefore, based on guidelines and a review of the evidence, the request for Zanaflex 4mg quantity 60.00 is not medically necessary.

**Interferential Stimulator purchase with supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that interferential current stimulation is not recommended as an isolated intervention and that there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Within the medical information available for review, there is documentation of diagnoses of cervical spine musculoligamentous sprain/strain with bilateral upper extremity radiculitis, cervical disc protrusions with mild central canal stenosis, cervical multilevel degenerative disc disease, thoracic spine musculoligamentous sprain/strain, bilateral

shoulder impingent syndrome, bursitis and periscapular myofascial strain, and bilateral forearm/wrist flexor and extensor tendinitis with dynamic carpal tunnel syndrome. In addition, there is documentation that the IF unit will be used in conjunction with recommended treatments, including home exercise and medications. However, there is no documentation of additional recommended treatments (return to work). In addition, given documentation of decreased pain levels, improved activities of daily living, and improved participation in home exercise program with use of medications, there is no documentation of limited evidence of improvement on recommended treatments alone (medications). Therefore, based on guidelines and a review of the evidence, the request for Interferential Stimulator purchase with supplies is not medically necessary.

**Physical Therapy to cervical spine, bilateral upper extremities (sessions) quantity 8.00:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of cervical spine sprain/strain with bilateral upper extremity radiculitis not to exceed 10 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of cervical spine musculoligamentous sprain/strain with bilateral upper extremity radiculitis, cervical disc protrusions with mild central canal stenosis, cervical multilevel degenerative disc disease, thoracic spine musculoligamentous sprain/strain, bilateral shoulder impingent syndrome, bursitis and periscapular myofascial strain, and bilateral forearm/wrist flexor and extensor tendinitis with dynamic carpal tunnel syndrome. In addition, there is documentation of a request to re-initiate physical therapy. However, the proposed number of sessions exceeds guidelines (for re-initiating a trial of physical therapy). Therefore, based on guidelines and a review of the evidence, the request for physical Therapy to cervical spine, bilateral upper extremities (sessions) quantity 8.00 is not medically necessary.