MAXIMUS Federal Services

Case Number:	CM14-0021421		
Date Assigned:	05/07/2014	Date of Injury:	10/21/2002
Decision Date:	07/09/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	02/20/2014

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 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 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 37-year-old female who reported an injury on 10/21/2002 due to an unknown mechanism. The clinical note dated 04/15/2014 indicated diagnoses of chronic pain due to trauma, myalgia/myositis, lumbosacral spondylosis without myelopathy, and sleep disturbances. The injured worker reported lower back pain that radiated to the left thigh which she described as achy, deep, discomforting, numbness, sharp, and shooting pain. The injured worker reported the pain was aggravated by bending, changing positions, coughing, daily activities, jumping, lifting, lying, rest, rolling over in bed, sitting, standing, and twisting. The injured worker reported the pain was relieved by heat and pain medications. The injured worker reported she was able to complete errands, cooking activities, putting on her shirt/jacket, drive, reach for seatbelt, sleep on affected side, style her hair, tuck in shirt, walk household distances, and wash armpits. The injured worker found it difficult to ascend and descend stairs, put on and take off shoes and socks, fasten and unfasten her brassiere, get into and out of the bathtub, and get in and out of the vehicle. She slept better and stood from a seated position. The injured worker reported having night sweats, anxiety, depression, and insomnia. On physical examination of the lumbar spine, the injured worker had active painful range of motion with limiting factors of pain. The lumbar spine flexion revealed moderate restriction, extension revealed moderate restriction, lateral bending revealed moderate restriction. The injured worker had right PSIS taught band with twitch response. Her left hip strength was decreased. The injured worker's right knee strength was decreased and right ankle and foot strength was decreased. The injured worker reported without medication her pain is rated at 10/10. With medication her pain is rated 6/10. With medication the patient was able to work/volunteer limited hours and take part in limited social activities on weekends. Without medication the injured worker reported she struggled but fulfilled her daily home responsibilities, no outside activity,

and was unable to work/volunteer. The injured worker was positive on 04/15/2014 for alcohol metabolites and in the past for methamphetamine/amphetamine. She denied usage but the physician could not satisfy an explanation, the injured worker was informed that physician could not continue to prescribe controlled substances. The injured worker was in a home conditioning program. The injured worker's work status is permanent and stationary. The injured worker's medication regimen included Silenor, Cymbalta, Tramadol HCL, Flexeril, Tizanidine HCL, and Lidoderm. The Request for Authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

TIZANIDINE HCL 4 MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63-66.

Decision rationale: The request for TIZANIDINE HCL 4 MG #30 is not medically necessary. The California MTUS Guidelines recommend the use of muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. There was lack of evidence in the objective evaluation to indicate the injured worker has spasms. In addition, the efficacy of the Tizanidine was not provided. Furthermore, the documentation provided indicates the injured worker has been prescribed muscle relaxants since at least 11/11/2013. This time frame exceeds the guidelines recommendations to be considered short-term of 2-3 weeks. Also, the request as submitted failed to provide the frequency of the medication. Therefore, the request for TIZANIDINE HCL 4 MG #30 is not medically necessary.

FLEXERIL 10 MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63-66.

Decision rationale: The request for Flexeril 10mg #60 is not medically necessary. The California MTUS Guidelines recommend the use of muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The clinical information indicates the injured worker's pain is chronic. The efficacy of the Flexeril was not provided to support continuation. In addition, there is lack of evidence in the clinical to indicate an acute exacerbation. Furthermore, the documentation provided indicates the injured worker has been prescribed muscle relaxants since at least 01/22/2013. This time

frame exceeds the time frame to be considered short-term of 2-3 weeks. Also, the request does not include the frequency of the medication. Therefore, the request is not medically necessary.

ONE TRIGGER POINT INJECTIONRIGHT POSTERIOR SUPERIOR ILIAC SPINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

Decision rationale: The request for ONE TRIGGER POINT INJECTION RIGHT POSTERIOR SUPERIOR ILIAC SPINE is not medically necessary. The California MTUS guidelines recommend Superior iliac spine trigger point injections only for myofascial pain syndrome as indicated below, with limited lasting value, and it is not recommended for radicular pain. Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met to include documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; symptoms have persisted for more than three months; medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; radiculopathy is not present; not more than 3-4 injections per session; no repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; frequency should not be at an interval less than two months; trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. Although there was a documented twitch response, there was no percent of pain relief documented and lack of evidence that NSAIDs and muscle relaxants have failed. Therefore, per the California MTUS Guidelines, the request for ONE TRIGGER POINT INJECTION RIGHT POSTERIOR SUPERIOR ILIAC SPINE is not medically necessary.

ONE FUNCTIONAL RESTORATION PROGRAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Page(s): 30-33.

Decision rationale: The request for ONE FUNCTIONAL RESTORATION PROGRAM is not medically necessary. The request for 1 functional restoration program consultation is non-certified. The California MTUS Guidelines recommend an adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement. There is a significant lack of evidence that an adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement in the documentation provided. Therefore, based on the

documentation provided, the request for ONE FUNCTIONAL RESTORATION PROGRAM is not medically necessary.