

Case Number:	CM14-0189719		
Date Assigned:	11/20/2014	Date of Injury:	04/06/1994
Decision Date:	01/08/2015	UR Denial Date:	10/24/2014
Priority:	Standard	Application Received:	11/13/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 patient is a 61 year old employee with date of injury 4/6/1994. Medical records indicate the patient is undergoing treatment for chronic neck pain, low back pain, right carpal tunnel syndrome, right shoulder and lumbar discogenic pain. Subjective complaints include ongoing and worsening neck and low back pain that radiates down both legs posteriorly on an intermittent basis, described as a constant ache; difficulty sleeping, constipation due to narcotics, pain and spasms right side neck, back spasms cause shooting pain down the arm and posterior shoulder region; pain and spasms increased when he tried to stop Zanaflex; pain without meds 9/10, decreases to 6-7/10 with medications. Objective complaints include tenderness in lumbar paraspinal muscles bilaterally with decreased range of motion (ROM) and positive bilateral leg lift, neurologically intact, decreased ROM to cervical and lumbar spine with spasms, pain with ROM, paraspinal tenderness noted, positive discogram. Treatment has consisted of left knee brace, TENS unit and massage therapy. Medications include Norco, Lunesta alternating with Ambien, Colace, Lactulose, Tizanidine, Lyrica, and Biofreeze. Right shoulder surgery in 2000, carpal tunnel release 2001 and 2009, left knee replacement 9/2006 and anterior discectomy with fusion C2-C7. The utilization review determination was rendered on 10/24/14 recommending non-certification of Decision for Lyrica 150mg # 60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrica 150mg # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines AED's Page(s): 16-17, 19-20.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregablin (Lyrica) Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Anti-epilepsy drugs (AEDs) for pain

Decision rationale: MTUS and ODG state that "Pregabalin (Lyrica) has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. Pregabalin was also approved to treat fibromyalgia. See Anti-epilepsy drugs (AEDs) for general guidelines, as well as specific Pregabalin listing for more information and references."Medical records do not indicate that this patient is being treated for neuropathy, postherpetic neuralgia or fibromyalgia. This patient's current medication regimen includes several pain medications and the treating physician has not detailed functional improvement on these medications. Additionally, the treating physician did not provide documentation detailing this patient's functional improvement from taking Lyrica. As such, the request for Lyrica 150mg # 60 is not medically necessary.

Massage Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Massage Therapy, Manual Therapy

Decision rationale: MTUS states regarding massage therapy, "Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases." ODG offers additional frequency and timeline for massage therapy by recommending:a. Time to produce effect: 4 to 6 treatments.b. Frequency: 1 to 2 times per week for the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks.c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life.Medical documentation provided indicates that this patient has utilized massage therapy in the past, but does not detail the number of treatments, frequency or duration of treatments. The treating physician has not provided objective findings in relation to the patient's response to previous treatment and functional improvement that was obtained. Without adequate information about this patient's utilization of the requested therapy the guideline recommendations cannot be applied. As such, the request for Massage Therapy is not medically necessary.