

Case Number:	CM15-0004559		
Date Assigned:	01/15/2015	Date of Injury:	09/24/2012
Decision Date:	03/26/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/09/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Pennsylvania
 Certification(s)/Specialty: Internal Medicine

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 61 year old female who sustained an industrial injury reported on 9/24/2012. She has reported long standing back pain described as spasms, aching, and with numbness and tingling down both legs, right & left. The diagnoses have included: chronic low back pain; degenerative disc disease - lumbar; facet arthropathy - lumbar; radiculitis right lower extremity (RLE) with neuropathic pain; left knee rule-out derangement; and depression. Treatments to date have included consultations, diagnostic imaging studies, physical therapy in 2009, and medication management. The work status classification for this injured worker was noted to be permanent and stationary. Magnetic resonance imaging of the lumbar spine on 10/26/12 was reported to show degenerative disc disease in the lumbar spine, multilevel facet changes, 3 millimeters grade I retrolisthesis of L3-4 and L4-5. The orthopedic physician's progress note of 11/26/2014 notes longstanding back pain currently 9 out of 10 in severity; the pain is made better with non-steroidal anti-inflammatories. Examination showed decreased sensation to pinprick in the right lower extremity lateral calf, decreased range of motion of the lumbar spine, tenderness along the L4 and L5 spinous process, and positive straight leg raise on the right. The treatment plan included epidural steroid injection (ESI), physical therapy, acupuncture, psychology referral, and medication changes. The injured worker reported dizziness with gabapentin, and the physician prescribed lyrica; tizanidine was prescribed for muscle spasms due to discontinuation of nonsteroidal anti-inflammatory medication in anticipation of the lumbar ESI. Examination by the primary treating physician on 11/26/14 showed normal lower extremity motor testing and deep tendon reflexes, no tenderness or spasm

in the paralumbar musculature, negative straight leg raise bilaterally, and diminished sensation in the left lower extremity. The primary treating physician noted a plan to continue diclofenac (a nonsteroidal anti-inflammatory medication NSAID). On 12/22/2014 Utilization Review (UR) non-certified, for medical the request for interlaminar epidural steroid injection to lumbar 5 - sacral 1, physical therapy evaluation lumbar spine, physical therapy lumbar spine 1 x a week for 6 weeks, manual therapy techniques lumbar spine 1 x a week for 6 weeks, acupuncture 1 x a week for 6 weeks, modified the request for Lyrica 75mg #30 with 2 refills - to no refills, and modified the request for tizanidine 2 mg #90 to #20. The Medical Treatment Utilization Schedule and the Official Disability Guidelines were cited by Utilization Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interlaminar epidural steroid injection, L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46.

Decision rationale: The MTUS, chronic pain section, page 46 describes the criteria for epidural steroid injections. Epidural injections are a possible option when there is radicular pain caused by a radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There must be documentation of failure of conservative treatment such as exercises, physical methods, nonsteroidal anti-inflammatory agents, and muscle relaxants. An epidural steroid injection must be at a specific side and level. In this case, there was no clear documentation of radiculopathy; the physical examinations documented by the orthopedist and the primary treating physician on the same date in November 2014 showed discrepant findings on sensory examination of the lower extremities and on straight leg raise testing, the MRI from 2012 was not consistent with radiculopathy at a specific nerve root level, more recent imaging was not documented, and no electrodiagnostic testing was documented. Due to the lack of clear documentation of radiculopathy, the request for epidural steroid injection is not medically necessary.

Physical therapy evaluation, lumbar spine: Upheld

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

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

Decision rationale: The records do not contain a sufficient prescription from the treating physician, which must contain diagnosis, duration, frequency, and treatment modalities, at a minimum. Reliance on passive care is not recommended. The physical medication prescription is

not sufficiently specific, and does not adequately focus on functional improvement. No functional goals were discussed. Per the MTUS chronic pain section, functional improvement is the goal rather than the elimination of pain. Physical medicine for chronic pain should be focused on progressive exercise and self care, with identification of functional deficits and goals, and minimal or no use of passive modalities. A non-specific prescription for physical therapy in cases of chronic pain is not sufficient. The injured worker was reported to have undergone prior physical therapy in 2009, without discussion of the specific number of treatments or results of treatment. The MTUS states that patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The injured worker should be able to transition to a home exercise program after the physical therapy already completed. Due to lack of a sufficient prescription, and lack of functional goals, the request for physical therapy evaluation is not medically necessary.

Physical therapy once a week for six weeks for the lumbar spine: Upheld

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

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

Decision rationale: The records do not contain a sufficient prescription from the treating physician, which must contain diagnosis, duration, frequency, and treatment modalities, at a minimum. Reliance on passive care is not recommended. The physical medication prescription is not sufficiently specific, and does not adequately focus on functional improvement. No functional goals were discussed. Per the MTUS chronic pain section, functional improvement is the goal rather than the elimination of pain. Physical medicine for chronic pain should be focused on progressive exercise and self care, with identification of functional deficits and goals, and minimal or no use of passive modalities. A non-specific prescription for physical therapy in cases of chronic pain is not sufficient. The injured worker was reported to have undergone prior physical therapy in 2009, without discussion of the specific number of treatments or results of treatment. The MTUS states that patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The injured worker should be able to transition to a home exercise program after the physical therapy already completed. Due to lack of a sufficient prescription, and lack of functional goals, the request for physical therapy once a week for 6 weeks to the lumbar spine is not medically necessary.

Manual therapy techniques once a week for six weeks for the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300, Chronic Pain Treatment Guidelines manual therapy p. 58-60 physical medicine p. 98-99 Page(s): 58-60.

Decision rationale: Per the MTUS for Chronic Pain, the purpose of manual medicine is functional improvement, progression in a therapeutic exercise program, and return to productive activities (including work). Per the MTUS for Chronic Pain, a trial of 6 visits of manual therapy and manipulation may be provided over 2 weeks, with any further manual therapy contingent upon functional improvement. Per the ACOEM, manipulation is an option in the first few weeks of back pain, but efficacy has not been proven for symptoms lasting longer than one month. The treating orthopedist documented in the progress note that physical therapy twice a week for 6 weeks was part of the treatment plan. It is possible that the manual therapy requested was intended to be a component of the prescription for physical therapy, but this was not made clear in the documentation provided. Per the MTUS, passive therapy can provide short term relief during the early phases of pain treatment but active therapy is preferred. The injured worker has had ongoing back pain for years, and is well past the first month of symptoms. Due to lack of a sufficient indication, the request for manual therapy is not medically necessary.

Acupuncture once a week for six weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Per the MTUS, acupuncture is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The MTUS recommends an initial trial of 3-6 visits of acupuncture. Frequency of treatment of 1-3 times per week with an optimum duration of 1-2 months is specified by the MTUS. The documentation provided notes that gabapentin was not tolerated due to dizziness, and that Lyrica was substituted. There was no documentation of intolerance to diclofenac or other pain medications. The associated physical therapy requested has been determined to be not medically necessary. No surgical intervention was documented or planned. For these reasons, the request for acupuncture is not medically necessary.

Refill of Lyrica 75mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anticonvulsants Page(s): 16-22.

Decision rationale: Per the MTUS, antiepilepsy drugs (AEDs) are recommended for neuropathic pain due to nerve damage. Lyrica (pregabalin) has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, and is FDA approved for these indications as well as for fibromyalgia. Side effects include edema, central nervous system depression, weight gain, blurred vision, somnolence, and dizziness. The documentation from the physician notes that gabapentin caused dizziness, and for this reason Lyrica was prescribed.

There is no documentation that the injured worker had diabetic neuropathy, postherpetic neuralgia, or fibromyalgia, the FDA approved indications for this medication. Due to the lack of an approved indication, the request for Lyrica is not medically necessary.

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Tizanidine 2mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. Tizanidine (Zanaflex) is FDA approved for management of spasticity and unlabeled for use for low back pain. Side effects include somnolence, dizziness, dry mouth, hypotension, weakness, and hepatotoxicity. Liver function tests should be monitored. It should be used with caution in renal impairment and avoided in hepatic impairment. Due to the lack of evidence of prescribing for an acute flare of low back pain, as well as quantity of medications not in accordance with the guideline recommendation for short term use, the request for tizanidine is not medically necessary.