

Case Number:	CM15-0038706		
Date Assigned:	03/09/2015	Date of Injury:	10/26/2012
Decision Date:	04/16/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	03/02/2015

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: California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 50-year-old female with an industrial injury dated October 26, 2012. The injured worker diagnoses include degeneration of cervical intervertebral disc, degeneration of lumbosacral intervertebral disc and carpal tunnel syndrome. She has been treated with diagnostic studies, radiographic imaging, prescribed medications, acupuncture, 12 sessions of aqua therapy, home exercise therapy, and periodic follow up visits. According to the progress note dated 1/23/2015, the injured worker reported bilateral neck pain and low back pain. The treating physician noted mild distress, anxious, antalgic gait favoring left, and tenderness over paraspinal muscles overlying the facet joints. The treating physician also noted facial grimacing, rubbing of neck and wrist and tearfulness. The treatment plan consists of recommendation for updated cervical MRI, continued aqua therapy, multidisciplinary authorization, continue with prescribed pain medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment, Cervical spine, 2 times weekly for 2 weeks: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

Decision rationale: The patient presents with bilateral neck and low back pain rated 8/10. The request is for chiropractic treatment, cervical spine, 2 times weekly for 2 weeks. The RFA is not provided. Patient's diagnosis included degeneration of cervical intervertebral disc, degeneration of lumbosacral intervertebral disc, and carpal tunnel syndrome. The reports do not reflect if the patient is working. Regarding Chiropractic, MTUS Manual Therapy and Manipulation guidelines pages 58, 59 state that treatment is "recommended for chronic pain if caused by musculoskeletal conditions...MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. MTUS page 8 also requires that the treater monitor the treatment progress to determine appropriate course of treatments. Treater does not state the reason for the request in detail. MTUS recommends an optional trial of 6 visits over 2 weeks and with evidence of objective functional improvement, up to 18 sessions. There is no evidence of prior chiropractic treatments for this patient and the requested 4 sessions appear reasonable. The request IS medically necessary.

Multidisciplinary evaluation: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs) Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration programs Page(s): 49.

Decision rationale: The patient presents with bilateral neck and low back pain rated 8/10. The request is for a multidisciplinary evaluation. The RFA is not provided. Patient's diagnosis included degeneration of cervical intervertebral disc, degeneration of lumbosacral intervertebral disc, and carpal tunnel syndrome. The reports do not reflect if the patient is working. The MTUS guidelines pg. 49 recommends functional restoration programs and indicate it may be considered medically necessary when all criteria are met including (1) adequate and thorough evaluation has been made (2) Previous methods of treating chronic pain have been unsuccessful (3) significant loss of ability to function independently resulting from the chronic pain; (4) not a candidate for surgery or other treatments would clearly be (5) The patient exhibits motivation to change (6) Negative predictors of success above have been addressed. In this case, the patient has persistent chronic pain for which MTUS supports functional restoration program. The request is for an evaluation to determine the patient's candidacy. The request IS medically necessary.

Tizanidine trial for muscle spasms: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for pain ANTISPASTICITY/ANTISPASMODIC DRUGS Page(s): 63-66.

Decision rationale: The patient presents with bilateral neck and low back pain rated 8/10. The request is for a tizanidine trial for muscle spasms. The RFA is not provided. Patient's diagnosis included degeneration of cervical intervertebral disc, degeneration of lumbosacral intervertebral disc, and carpal tunnel syndrome. The reports do not reflect if the patient is working. MTUS Chronic Pain Medical Treatment Guidelines for Muscle Relaxants for pain, pg 66, "Antispasticity/Antispasmodic Drugs: Tizanidine (Zanaflex, generic available) is a centrally acting alpha₂-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain." MTUS p60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. MTUS Guidelines pages 63 through 66 state "recommended non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic low back pain." They also state "This medication has been reported in case studies to be abused for euphoria and to have mood elevating effects." Tizanidine is FDA approved for management of spasticity and unlabeled use for low back pain, from which the patient is reportedly suffering. Guidelines recommend only a short-term use of the medication. In this case, the prescription for Tizanidine is first noted in progress report dated 01/23/15 and it appears that the patient is starting using this medication with this prescription. A short-term use of this medication may be reasonable, however, the treater has not indicated the quantity for this request. Given the inadequate information for assessment, the request IS NOT medically necessary. Tizanidine is FDA approved for management of spasticity and unlabeled use for low back pain which the patient is reportedly suffering from. Guidelines recommend only a short-term use of the medication. In this case, the prescription for Tizanidine is first noted in progress report dated 01/23/15 and it appears that the patient is starting using this medication with this prescription. A short term use of this medication may be reasonable, however, the treater has not indicated the quantity for this request. Given the inadequate information for assessment, the request IS NOT medically necessary.