

<b>Case Number:</b>	CM15-0047393		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	02/10/2007
<b>Decision Date:</b>	04/24/2015	<b>UR Denial Date:</b>	02/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2015

### 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, Pain Management

### 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 56 year old male, who sustained a work/ industrial injury on 2/10/07. He has reported initial symptoms of neck pain and bilateral shoulder pain. The injured worker was diagnosed as having bilateral shoulder pain, chronic pain, s/p right shoulder surgery, left lower extremity deep venous thrombosis. Treatments to date included medication and diagnostics. X-ray of the right ankle noted no evidence of fracture, os trigonum, calcification in the insertion of the Achilles tendon likely due to chronic tendinitis. X-ray of right foot was negative. Right lower extremity venous doppler deep vein thrombosis of the popliteal vein. Currently, the injured worker complains of neck pain and low back pain with radiation down both lower extremities rated 6-7/10 and insomnia. The treating physician's report (pain medicine re-evaluation) from 2/2/15 indicated the injured worker was in moderate distress, had tenderness with palpation in the shoulder region, decreased range of motion of the right shoulder, tenderness with palpation, and had mild swelling in the calf. Medications included Tizanidine, Coumadin, and Seroquel. Treatment plan included Aqua therapy 2 times a week for 4 weeks, Physical Therapy/ Occupational Therapy, and Tizanidine. Notes indicate that the patient has previously undergone aquatic therapy and failed land-based therapy. The progress report identifies low back pain radiating into the lower extremities. The note indicates that his muscle relaxant and opioid pain medication are helpful and that due to previous therapy the patient in its function has improved in his quality of life has improved. Physical examination reveals tenderness in the lower extremities with decreased range of motion in the shoulder. The treatment plan includes a gym membership for pool access.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Aqua therapy 2 times a week for 4 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 22, 98-99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for aquatic therapy, Chronic Pain Treatment Guidelines state that aquatic therapy is recommended as an optional form of exercise therapy where available as an alternative to land-based physical therapy. They go on to state that it is specifically recommended whenever reduced weight bearing is desirable, for example extreme obesity. Guidelines go on to state that for the recommendation on the number of supervised visits, see physical therapy guidelines. Within the documentation available for review, there is no indication as to how many aquatic therapy sessions the patient has undergone and what specific objective functional improvement has been obtained with the therapy sessions already provided. Additionally, it is unclear what objective functional treatment goals are currently present which would be expected to improve with additional aquatic therapy. Furthermore, it appears the patient has become independent with the current exercise program as the requesting physician has asked for a gym membership for pool access. Finally, there is no statement indicating whether the patient is performing a home exercise program on a regular basis, and whether or not that home exercise program has been modified if it has been determined to be ineffective. In the absence of clarity regarding those issues, the currently requested aquatic therapy is not medically necessary.

**Tizanidine 4mg twice a day #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

**Decision rationale:** Regarding the request for tizanidine (Zanaflex), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that tizanidine specifically is FDA approved for management of spasticity; unlabeled use for low back pain. Guidelines recommend LFT monitoring at baseline, 1, 3, and 6 months. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the tizanidine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, it does not appear that there has been appropriate liver function testing, as recommended by guidelines. In the absence of such documentation, the currently requested tizanidine (Zanaflex) is not medically necessary.