

Case Number:	CM14-0096896		
Date Assigned:	07/28/2014	Date of Injury:	04/05/2004
Decision Date:	10/16/2014	UR Denial Date:	06/19/2014
Priority:	Standard	Application Received:	06/25/2014

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 Family Medicine and is licensed to practice in Tennessee, Florida and California. 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 59 year old male injured on 04/05/04 due to undisclosed mechanism of injury. Diagnosis included C6-7 degenerative disc disease with chronic left C7 radiculopathy. The injured worker underwent conservative treatment including diagnostic studies, medication management, and epidural steroid injections. Clinical note dated 06/11/14 indicated the injured worker complained of 25% increase in left neck, trapezius, and interscapular pain rated 8/10. The injured worker reported pain radiating to the deltoids; however, denied numbness, weakness, loss of bowel or bladder control. Physical examination revealed pain with cervical range of motion, upper extremities range of motion pain free, deep tendon reflexes of bilateral upper extremities 2+, and left trapezius muscle tender. Treatment plan included eight sessions of functionally oriented physical therapy, Orudis 50mg BID, Protonix 20mg two tablets QAM, increase Lyrica to 100mg BID, and Zanaflex 4mg TID. The initial request was non-certified on 06/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy QTY 8.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Page(s): 98.

Decision rationale: As noted on page 98 of the Chronic Pain Medical Treatment Guidelines, current guidelines recommend 10 visits over 8 weeks for the treatment of cervical intervertebral disc displacement and allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home physical therapy including assessment after a six-visit clinical trial. The request exceeds the recommended trial period to establish functional improvement. As such, the request for Physical Therapy QTY 8.00 cannot be recommended as medically necessary.

Lyrica to 100mg QTY 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica), Page(s): 99.

Decision rationale: As noted on page 99 of the Chronic Pain Medical Treatment Guidelines, Pregabalin (Lyrica) has been documented to be effective in treatment of diabetic neuropathy, postherpetic neuralgia, and is considered first-line treatment for both. Pregabalin was also approved to treat fibromyalgia. There is no indication in the documentation that the injured worker has been diagnosed with fibromyalgia or has objective findings consistent with neuropathic pain. Additionally, there is no indication of reassessment of the benefit associated with the use of Lyrica. As such, the request for Lyrica to 100mg QTY 1.00 cannot be recommended as medically necessary.

Zanaflex 4mg QTY 1.00 (not provided): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

Decision rationale: As noted on page 63 of the Chronic Pain Medical Treatment Guidelines, muscle relaxants are recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the injured worker has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. As such, the medical necessity of Zanaflex 4mg QTY 1.00 (not provided) cannot be established at this time.