

Case Number:	CM15-0114166		
Date Assigned:	06/22/2015	Date of Injury:	09/30/1999
Decision Date:	07/21/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	06/12/2015

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, Indiana, New York
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:

This 58 year old woman sustained an industrial injury on 9/30/1999. The mechanism of injury is not detailed. Diagnoses include cervical spine sprain/strain, lumbar spine sprain/strain, and chronic myofascial pain syndrome. Treatment has included oral medications and surgical intervention. Physician notes on a PR-2 dated 4/30/2015 show complaints of right shoulder pain rated 7-8/10 and intermittent to frequent low back flare-ups rated 6/10 with numbness and tingling radiating to the bilateral lower extremities. Recommendations include physical therapy, Norco, Zanaflex, continue home exercise program, and follow up in four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 x 4, right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Physical therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy two times per week times four weeks to the right shoulder is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are strain sprain cervical spine, status post anterior cervical discectomy and fusion; sprain strain of lumbar spine; status post right shoulder SAD & DCR; and chronic myofascial pain syndrome. The request for authorization and most recent progress note is dated April 30, 2015. Subjectively, the injured worker complains of right shoulder pain 7-8/10 and low back pain. The injured worker experienced frequent flare-ups of low back pain. The documentation indicates that reflects has been used for "a couple of years" and has been tapered to its present dose. Objectively, there is tenderness palpation over the shoulder and tenderness palpation with spasm in the lumbar paraspinal muscle groups. The injured worker underwent previous physical therapy post surgery. There is no documentation of prior physical therapy in the medical record, total number of physical therapy sessions to date and whether there was objective functional improvement. There is no indication the worker is engaged in a home exercise program. Consequently, absent medical documentation with prior physical therapy, total number of physical therapy sessions to date, objective functional improvement and compelling clinical facts indicating additional physical therapy is warranted, physical therapy two times per week times four weeks to the right shoulder is not medically necessary.

Physical therapy 2 x 4, cervical spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, Physical therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy two times per week times four weeks to the cervical spine is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are strain sprain cervical spine, status post anterior cervical discectomy and fusion; sprain strain of lumbar spine; status post right shoulder SAD & DCR; and chronic myofascial pain syndrome. The request for authorization and most recent progress note is dated April 30, 2015. Subjectively, the injured worker complains of right shoulder pain 7-8/10 and low back pain. The injured worker experienced frequent flare-ups of low back pain. The documentation indicates that reflects has been used for "a couple of years" and has been tapered to its present dose. Objectively, there is tenderness palpation over the shoulder and tenderness palpation with spasm in the lumbar paraspinal muscle groups. According to the April 30, 2015 progress note, there are no cervical spine subjective complaints. Objectively, there were no cervical objective findings. The injured worker received prior physical therapy post surgery. There is no documentation of prior physical therapy in the medical record, total number of physical therapy sessions to date and whether there was objective functional improvement. There is no indication the worker is engaged in a home exercise program. There are no compelling

clinical facts indicating additional physical therapy is clinically warranted. Consequently, absent medical documentation with prior physical therapy, total number of physical therapy sessions to date, objective functional improvement and compelling clinical facts indicating additional physical therapy is warranted, physical therapy two times per week times four weeks to the cervical spine is not medically necessary.

Zanaflex 4mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Muscle relaxants.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Zanaflex 4 mg #30, one is not medically necessary. Muscle relaxants are recommended as a second line option short-term (less than two weeks) of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time and prolonged use may lead to dependence. In this case, the injured worker's working diagnoses are strain sprain cervical spine, status post anterior cervical discectomy and fusion; sprain strain of lumbar spine; status post right shoulder SAD & DCR; and chronic myofascial pain syndrome. The request for authorization and most recent progress note is dated April 30, 2015. Subjectively, the injured worker complains of right shoulder pain 7-8/10 and low back pain. The injured worker experienced frequent flare-ups of low back pain. The documentation indicates that reflects has been used for "a couple of years" and has been tapered to its present dose. Objectively, there is tenderness palpation over the shoulder and tenderness palpation with spasm in the lumbar paraspinal muscle groups. According to the April 30, 2015 progress note, there are no cervical spine subjective complaints. Objectively, there were no cervical objective findings. Zanaflex is indicated for short-term treatment of acute exacerbations in chronic low back pain and acute low back pain. There is no documentation of acute low back pain or an acute exacerbation of chronic low back pain. Additionally, the documentation indicates Zanaflex has been prescribed "for a couple of years". The guidelines recommend short-term (less than two weeks). There are no compelling clinical facts indicating Zanaflex is indicated long-term. Consequently, absent compelling clinical documentation with acute low back pain or an acute exacerbation of chronic low back pain and treatment in excess of the recommended guidelines for short-term use (less than two weeks), Zanaflex 4 mg #30, one is not medically necessary.