

<b>Case Number:</b>	CM15-0002983		
<b>Date Assigned:</b>	01/13/2015	<b>Date of Injury:</b>	03/10/2014
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2015

### 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: New York, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency 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 (IW) is a 51-year-old female who sustained an industrial injury on 03/10/2014. Diagnoses include cervical spine and lumbar spine sprain/strain and right shoulder sprain/strain. Treatment to date has included medications, chiropractic treatment and physical therapy. According to the PR2 dated 11/24/14 the IW reported resolution of numbness and tingling in the right wrist since the cortisone injection received on 11/4/14. She complained of neck pain radiating to the right hand with numbness and tingling as well as low back pain radiating to the right foot with numbness and tingling. Electrodiagnostic testing of the bilateral lower extremities on 10/8/14 found evidence of right peroneal neuropathy, chronic right L4 radiculopathy and possibly right S1 radiculopathy. MRI of the cervical spine on 7/8/14 found ossification/calcification of the posterior longitudinal ligament with disc bulging from C2-C6 causing mild to moderate central canal stenosis; the lumbar spine MRI demonstrated prior hemilaminectomy and a 6mm disc protrusion and facet hypertrophy causing central canal and bilateral neuroforaminal narrowing at L3-4 and a 7mm disc protrusion and facet hypertrophy causing spinal canal and neuroforaminal narrowing at L5-S1. Findings of the right wrist MRI on 7/20/14 were tendinitis versus partial tear of the extensor carpi ulnaris tendon at the level of the ulnar styloid process. On examination, there was tenderness in the cervical and lumbar paraspinal muscles and the trapezius muscles. Range of motion was limited in the cervical and the lumbar spine. Compression test was positive to the right upper extremity and straight leg raise test was positive to the right calf. A request was made for Tylenol #4, #120 for treatment of chronic pain syndrome (Ultram ER was to be discontinued), Zanaflex 2mg, #120 for treatment of spasms,

a pain management consultation in consideration of spinal injections, one interferential stimulator and four chiropractic treatments for cervical and lumbar traction for radicular complaints.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Tylenol #4 #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

**Decision rationale:** Guidelines support short term use of opiates for moderate to severe pain after first line medications have failed. Long term use may be appropriate if there is functional improvement and stabilization of pain without evidence of non-compliant behavior. In this case, there is no documentation of failure of first line medications. The request for Tylenol#4 #120 is not medically appropriate or necessary.

**Zanaflex 2mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-64.

**Decision rationale:** Guidelines recommend muscle relaxants as a second line option for short term treatment of acute exacerbations of pain, but they do not show any benefit beyond NSAIDs. In this case, there is no evidence to suggest significant muscle spasm to warrant the use of this medication. The request for Zanaflex 2 mg #120 is not medically appropriate or necessary.

**Pain Management Consultation with [REDACTED]: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** Guidelines recommend specialty consultation when the diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. In this case, there is no documentation of what specific conservative treatment this patient has received to treat the pain or description of specific subjective complaints or objective findings which might warrant a pain medicine

consultation. The request for pain medicine consultation is not medically appropriate or necessary.

**Interferential Stimulator:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Stimulation.

**Decision rationale:** According to guidelines, interferential current stimulation is not recommended as an isolated intervention but may be considered if the pain is ineffectively controlled by medications and there is a history of substance abuse. In this case, there is no documented justification provided to supersede the guideline recommendations. The request for interferential unit rental and associated supplies is not medically necessary or appropriate.

**Chiropractic Treatment cervical and lumbar traction x4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines manual Therapy and Manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy and manipulation.

**Decision rationale:** Guidelines note that chiropractic treatment is used as an option to treat chronic pain caused by musculoskeletal conditions. Guidelines recommend an initial trial of 6 sessions over 2 weeks and continued if there is functional improvement. In this case, there is no documentation of any recent formal PT or home exercise program and it is not clear if there has been prior chiropractic treatment. Although cervical traction may be appropriate, guidelines do not recommend lumbar traction. The request for chiropractic treatment cervical and lumbar x4 is not medically appropriate or necessary.