

Case Number:	CM15-0168566		
Date Assigned:	09/09/2015	Date of Injury:	10/01/2001
Decision Date:	10/08/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	08/27/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 70 year old male, who sustained an industrial injury on October 1, 2001. The mechanism of injury was not provided in the medical records. The diagnoses have included chronic pain syndrome, left foot pain with plantar fasciitis (improved), left knee pain, right cervical-six radiculopathy, left rotator cuff tear, left meniscus tear, right ulnar neuropathy, bilateral lower extremity lumbar-five radicular symptoms and spasticity with muscle spasm. The injured worker was noted to be temporarily totally disabled. Current documentation dated August 6, 2015 notes that the injured worker reported neck pain with numbness and tingling from the neck to the right thumb and numbness and tingling of the lower extremities. Examination of the neck revealed tenderness to palpation on the right side with radicular symptoms. Sensation was decreased in the cervical-six distributions. The injured worker was noted to have erythema in the bilateral lower extremities with pain and tenderness of the plantar aspect of the foot and fourth and fifth digit. Documentation dated July 13, 2015 notes that the injured worker had spasticity of the muscle groups of the neck and low back. The documentation also notes that the injured worker did not have prior electrodiagnostic studies performed. Documented treatment to date has included medications, a transcutaneous electrical nerve stimulation unit and a home exercise program. Current medications include Zanaflex (prescribed since 7-13-2015), Cymbalta, Vitamin D2, Crestor, Mobic, Prilosec and Mirapex. The treating physician's request for authorization included requests for Zanaflex 4 mg # 60 and electromyography and nerve conduction studies of the lower extremities. The original utilization review dated August 18, 2015 not-certified the request for Zanaflex 4 mg # 60 due to lack of documentation of spasticity and no documentation of significant functional improvement with the use of muscle relaxants. Utilization review non-certified the request for electromyography

and nerve conduction studies of the lower extremities due to lack of a differential diagnosis to support the studies and no documentation of previous imaging results to compare to the injured workers current examination findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The California chronic pain medical treatment guidelines section on muscle relaxants states: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) (Chou, 2004) This medication is not intended for long-term use per the California MTUS. The medication has not been prescribed for the flare-up of chronic low back pain. This is not an approved use for the medication. For these reasons, criteria for the use of this medication have not been met. Therefore, the request is not medically necessary.

EMG and nerve conduction study of the lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapters on low back complaints and the need for lower extremity EMG/NCV states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. There are unequivocal objective findings of nerve

compromise on the neurologic exam provided for review. However there is not mention of surgical consideration. There are no unclear neurologic findings on exam. For these reasons, criteria for lower extremity EMG/NCV have not been met as set forth in the ACOEM. Therefore, the request is not medically necessary.