

Case Number:	CM15-0058529		
Date Assigned:	04/03/2015	Date of Injury:	08/15/2007
Decision Date:	05/04/2015	UR Denial Date:	02/20/2015
Priority:	Standard	Application Received:	03/27/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 47 year old male who sustained an industrial injury on 8/15/07. The mechanism of injury was unclear. He currently complains of lower back pain and spasms radiating to lower extremities. In addition, he has constant neck pain and bilateral shoulder pain and spasms with frequent headaches. His pain intensity is 7-8/10. He has restricted lumbar and cervical range of motion. Medications are Zanaflex and Percocet. Diagnoses include lumbar/ cervical discogenic disease; lumbar/ cervical radiculitis; lumbar/ cervical facet syndrome. Treatments to date include medications; physical therapy, which he was unable to tolerate; lumbar medial branch blocks (9/11/14) with limited reduction in pain symptoms; lumbar transforaminal epidural steroid injection (4/24/14). In the progress note date 2/13/15 the treating provider's plan of care includes a request for Zanaflex. Medication is helpful in allowing him to maintain his activities of daily living, decrease pain and spasms significantly, and maintain functional capacity. The request for transcutaneous electrical nerve stimulator unit was noted as it helps to reduce pain and spasms. He uses the unit daily and his current unit is no longer working.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4mg Qty 120, take 4 times per day (prescribed 2-13-15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, pg 128.

Decision rationale: Guidelines do not recommend long-term use of this muscle relaxant for this chronic injury. Additionally, the efficacy in clinical trials has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Submitted reports have not adequately demonstrated the indication or medical need for this treatment and there is no report of significant clinical findings, acute flare-up or new injury to support for its long-term use. There is no report of functional improvement resulting from its previous treatment to support further use as the patient remains not working. The Zanaflex 4mg Qty 120, take 4 times per day (prescribed 2-13-15) is not medically necessary and appropriate.

TENS (transcutaneous electrical nerve stimulation) Unit - Purchase for Lumbar Spine:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - TENS (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain, pages 114-117.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in conjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, the patient has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive physical therapy, activity modifications, yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, whether this is for rental or purchase, nor is there any documented short-term or long-term goals of treatment with the TENS unit. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the treatment already rendered. The TENS (transcutaneous electrical nerve stimulation) Unit - Purchase for Lumbar Spine is not medically necessary and appropriate.