

Case Number:	CM14-0115757		
Date Assigned:	08/04/2014	Date of Injury:	08/09/2013
Decision Date:	10/08/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/23/2014

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 Occupational Medicine and is licensed to practice in 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic low back, neck, shoulder, and myofascial pain syndrome reportedly associated with an industrial injury of August 9, 2013. In a Utilization Review Report dated July 1, 2014, the claims administrator approved a request for electrodiagnostic testing of the right upper extremity, denied an OrthoStim4 modality transcutaneous electric therapy device, denied 12 sessions of manipulative therapy, denied a request for Zanaflex, denied a request for naproxen, and denied x-rays of the cervical spine. The claims administrator stated that it was basing its decision on a March 19, 2014 Doctor's First Report. Said Doctor's First Report, however, was not incorporated into the Independent Medical Review packet medical evidence log furnished by the claims administrator. The applicant's attorney subsequently appealed. In a handwritten progress note dated April 7, 2014 and April 10, 2014, the applicant received chiropractic manipulative therapy treatment, also involved application of hot and cold packs as well as electrical muscle stimulation. The applicant's work status was not clearly outlined. There was no mention of medication selection or medication efficacy on the handwritten chiropractic progress notes of April 3, 2014, April 7, 2014, and/or April 10, 2014. In an earlier progress note of January 16, 2014, the applicant reported ongoing complaints of wrist and hand pain following an electrocution injury. The applicant was apparently "Nokavana 300 mg," it was stated at that point in time.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription of Anaprox DS 550 mg, #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

Decision rationale: The request for Anaprox (naproxen), an anti-inflammatory medication, is medically necessary, medically appropriate, and indicated here. As noted on page 22 of the MTUS Chronic Pain Medical Treatment Guidelines, anti-inflammatory medications such as naproxen (Anaprox) do represent the traditional first line of treatment for various chronic pain conditions, including the chronic pain syndrome reportedly present here. Based on the admittedly limited information on file, the request in question did represent a first-time request for the same, apparently initiated on a Doctor's First Report of March 19, 2014. It is acknowledged, however, that said progress note of March 19, 2014 was not incorporated into the Independent Medical Review packet. Nevertheless, based on the information on file, it appears that the request for naproxen did represent a first-time request for the same. Introduction of naproxen was indicated, appropriate, and supported by page 22 of the MTUS Chronic Pain Medical Treatment Guidelines.

One prescription of Zanaflex 4 mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine/Zanaflex Page(s): 66.

Decision rationale: The request for Zanaflex is not medically necessary, medically appropriate, or indicated here. While page 66 of the MTUS Chronic Pain Medical Treatment Guidelines notes that tizanidine or Zanaflex is FDA approved in the management of spasticity and can be employed off label for low back pain, in this case, however, there was no mention of low back pain either in the Utilization Review Report of July 1, 2014 or on the progress notes of the applicant's earlier treating provider dated January 15, 2014. The applicant's principal pain generators, per the Utilization Review Report, included the shoulder and neck. Per the January 15, 2014 progress note, the applicant's principal pain generators as of that point in time were the wrist and hand. No rationale for selection of Zanaflex was proffered either by the attending provider or applicant's attorney, although it is acknowledged that the March 19, 2014 Doctor's First Report on which this and several of the items in question were requested were not incorporated into the Independent Medical Review packet. The information which is on file, however, does not support or substantiate the request.

Twelve chiropractic sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION Page(s): 59-60.

Decision rationale: The request for 12 sessions of chiropractic manipulative therapy is not medically necessary, medically appropriate, or indicated here. While pages 59 and 60 of the MTUS Chronic Pain Medical Treatment Guidelines do support up to 24 sessions of manipulative treatment in applicants who demonstrate treatment success by achieving and/or maintaining successful return to work status, in this case, however, the applicant's response to earlier unspecified amount of manipulative therapy was not clearly outlined. The applicant's work status was not clearly stated or specified on the earlier chiropractic progress notes of April 7, 2014 and April 10, 2014, referenced above. Therefore, the request for 12 additional sessions of chiropractic treatment is not medically necessary.

One home Ortho-Stim 4 unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS); Neuromuscular Electrical.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GALVANIC STIMULATION; NEUROMUSCULAR ELECTRICAL STIMULATION Page(s): 115; 121. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.vqorthocare.com/products/orthostim-4-surgistim-4/>

Decision rationale: The OrthoStim home unit is likewise not medically necessary, medically appropriate, or indicated here. Based on the product description, the OrthoStim device represents a multimodality transcutaneous electric therapy device. Some of the modalities incorporated into the device include high-voltage current stimulation and neuromuscular electrical stimulation. However, as noted on page 117 of the MTUS Chronic Pain Medical Treatment Guidelines, galvanic stimulation or high-voltage stimulation, is "not recommended" in the chronic pain context present here and is considered investigational for all purposes. Similarly, neuromuscular electrical stimulation (NMES), another modality and device in question, is likewise not recommended in the chronic pain context present here, it was suggested on page 121 of the MTUS Chronic Pain Medical Treatment Guidelines. Since one or more modalities in the device in question are recommended, the entire device is not recommended.