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| Case Number: | CM15-0119516 | | |
| Date Assigned: | 06/24/2015 | Date of Injury: | 04/25/2013 |
| Decision Date: | 07/29/2015 | UR Denial Date: | 05/08/2015 |
| Priority: | Standard | Application Received: | 05/21/2015 |

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: Texas, California
 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 61 year old male, who sustained an industrial/work injury on 4/25/13. He reported initial complaints of lower back pain. The injured worker was diagnosed as having lumbar spondylosis, chronic pain, and low back pain. Treatment to date has included medication, transcutaneous electrical nerve stimulation (TENS) unit, and diagnostics. MRI results demonstrated mild to moderate multi-level degenerative changes. Currently, the injured worker complains of lower back pain. Per the primary physician's progress report (PR-2) on 3/11/15, examination revealed tenderness mid to palpation along paraspinal regions, normal range of motion, no bony tenderness and no deformity. Current plan of care included medication and replacement pads for transcutaneous electrical nerve stimulation (TENS) unit. The requested treatments include Tizanidine 2mg, TENS (Transcutaneous Electrical Nerve Stimulation) unit, and Back brace. Per note dated 6/2/15 patient had complaints of low back pain. Physical examination of the low back revealed tenderness on palpation and normal ROM. The medication list include Norco and Tylenol#3, Xanax, Paxil and Zanaflex. Patient sustained the injury due to lifting a heavy weight. Patient has received an unspecified number of PT visits for this injury. The patient has had X-ray and MRI of the lumbar spine that revealed degenerative changes. Any surgical or procedure note related to this injury were not specified in the records provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 2mg #60 with 1 refill: Overturned

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 ANTISPASTICITY/ANTISPASMODIC DRUGS: Tizanidine (Zanaflex) page 66.

Decision rationale: Request: Tizanidine 2mg #60 with 1 refill. According to MTUS guidelines Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. May also provide benefit as an adjunct treatment for fibromyalgia. He reported initial complaints of lower back pain. The injured worker was diagnosed as having lumbar spondylosis, chronic pain, and low back pain. MRI results demonstrated mild to moderate multi-level degenerative changes. Per note dated 6/2/15 patient had complaints of low back pain. Physical examination of the low back revealed tenderness on palpation. Patient sustained the injury due to lifting a heavy weight. Patient has received an unspecified number of PT visits for this injury. The patient has had X-ray and MRI of the lumbar spine that revealed degenerative changes. The patient has had significant abnormal objective findings. The patient's condition is prone to exacerbations. The prescription of a non sedating muscle relaxant like tizanidine for prn use during exacerbations is medically appropriate and necessary. The request for Tizanidine 2mg #60 with 1 refill is medically appropriate and necessary in this patient at this time.

TENS (Transcutaneous Electrical Nerve Stimulation) unit 3 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) page 114.

Decision rationale: TENS (Transcutaneous Electrical Nerve Stimulation) unit 3 months. According the cited guidelines, electrical stimulation (TENS), is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Recommendations by types of pain: A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence

for the use of TENS as noted below), and for CRPS I (with basically no literature to support use). According the cited guidelines, Criteria for the use of TENS is there is evidence that other appropriate pain modalities have been tried (including medication) and failed. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. Any evidence of neuropathic pain, CRPS I and CRPS II was not specified in the records provided. The details of PT or other types of therapy done since the date of injury were not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. A detailed response to previous conservative therapy was not specified in the records provided. Previous conservative therapy notes were not specified in the records provided. In addition a treatment plan including the specific short- and long-term goals of treatment with the TENS unit was not specified in the records provided. The records provided did not specify any recent physical therapy with active PT modalities or a plan to use TENS as an adjunct to a program of evidence-based functional restoration. Any evidence of diminished effectiveness of medications or intolerance to medications or history of substance abuse was not specified in the records provided. The request for TENS (Transcutaneous Electrical Nerve Stimulation) unit 3 months is not fully established for this patient. The request is not medically necessary.

Back brace, quantity: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 07/17/15) Lumbar supports.

Decision rationale: Back brace, quantity: Per the ACOEM guidelines cited below "There is no evidence for the effectiveness of lumbar supports in preventing back pain in industry." In addition per the ODG cited below regarding lumbar supports/brace, "Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). Under study for post-operative use; see Back brace, post operative (fusion)." Patient has received an unspecified number of PT visits for this injury. Response to prior conservative therapy was not specified in the records provided. Prior conservative therapy notes were not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. There is no evidence of instability, spondylolisthesis, lumbar fracture or recent lumbar surgery. Any surgery or procedure note related to this injury was not specified in the records provided. The medical necessity, of Back brace, quantity is not fully established.