

<b>Case Number:</b>	CM15-0144488		
<b>Date Assigned:</b>	08/05/2015	<b>Date of Injury:</b>	03/13/2015
<b>Decision Date:</b>	10/05/2015	<b>UR Denial Date:</b>	07/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/25/2015

### 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, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational 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 61-year-old male who sustained an industrial injury on 03/13/2015. He reported pain in the back radiating into the right leg, right gluteal area, posterior thigh, and posterior lower leg stopping at the heel. The injured worker was diagnosed of Spondylolisthesis, lumbar; Stenosis, Lumbar; Degenerative disc disease, Lumbar; Herniated disc, lumbar; Spondylolisthesis, degenerative-Acquired. Treatment to date has included physical therapy and medications. Currently, the injured worker complains of pain in the low back, leg, and arm. The low back pain radiates to the right leg, right gluteal area, posterior thigh to the posterior side of the lower leg stopping at the heel. Numbness, tingling and weakness are present at the L2-3 dermatomes and in the arm along C8 dermatome. He rates his pain as a 9-10 on a scale of 0-10. He also complains of pain in the right arm on the medial boarder. His pain is relieved by lying on the floor and medication. Objectively, there is tenderness to palpation and muscle guarding in the cervical spine. There was tenderness right greater than left and decreased range of motion in the thoracic spine. In the lumbar spine there was tenderness with muscle guarding right greater than left with decreased range of motion. There was point tenderness over the right sacroiliac joint. Reflexes in the upper extremity on the right, there was decreased sensitivity to pinprick and light touch at the median and nerve distribution. In the right lower extremity, there was altered sensation in the L4 and L5 dermatomes. There was no weakness or altered gait. Treatment plan includes chiropractic care, medications, home electrical muscle stimulation kit, and consultations with specialists. A request for authorization was made for the following: 1. Home electrical muscle stimulation unit, 2. Zanaflex 2mg one tablet orally three times daily as

needed x 120, 3. Consultation with a psychiatric specialist, 4. Consultation with a sleep specialist, 5. Short course of chiropractic therapy with adjunctive physiotherapy and chiropractic manipulative therapy 2 x wk. x 4 wks, Spine and right sacroiliac joint, 6. MEDs x 2: Norco 5/325mg. Recommended: One tab every six hours as needed x 120.

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

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

**Home electrical muscle stimulation unit: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Electrical muscle stimulation (EMS).

**Decision rationale:** The injured worker sustained a work related injury on 03/13/2015. The medical records provided indicate the diagnosis of Spondylolisthesis, lumbar; Stenosis, Lumbar; Degenerative disc disease, Lumbar; Herniated disc, lumbar; Spondylolisthesis, degenerative-Acquired. Treatment to date has included physical therapy and medications. The medical records provided for review do not indicate a medical necessity for Home electrical muscle stimulation unit. There were no appropriate guidelines to cite. The MTUS states that neuromuscular electrical stimulation (NMES devices) is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. The Official Disability Guidelines mentioned this only in the neck chapter where it stated that the current evidence on electrical Muscle stimulation is either lacking, limited, or conflicting; and that there is limited evidence of any benefit from electric muscle stimulation compared to a sham control for pain in chronic mechanical neck disorders (MND). Medscape and National Guidelines Clearinghouse are silent on the topic and therefore is not medically necessary.

**Zanaflex 2mg one tablet orally three times daily as needed x 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 (for pain) Page(s): 63-66.

**Decision rationale:** The injured worker sustained a work related injury on 03/13/2015. The medical records provided indicate the diagnosis of Spondylolisthesis, lumbar; Stenosis, Lumbar; Degenerative disc disease, Lumbar; Herniated disc, lumbar; Spondylolisthesis, degenerative- Acquired. Treatment to date has included physical therapy and medications. The medical records provided for review do not indicate a medical necessity for Zanaflex 2mg one tablet orally three times daily as needed x 120. The MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in

patients with chronic low back pain. Zanaflex (Tizanidine) is a muscle relaxant with recommended dosing of 4 mg initial dose; titrate gradually by 2-4 mg every 6-8 hours until therapeutic effect with tolerable side-effects; maximum 36 mg per day. The side effects include sleepiness, somnolence, dizziness, dry mouth, hypotension, weakness, and liver injury. When this medication is used, the MTUS recommends testing for liver function test at baseline, 1, 3, and 6 months). The requested is for about one month supply, but there is no evidence of liver function monitoring and therefore is not medically necessary.

**Consultation with a psychiatric specialist:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

**Decision rationale:** The injured worker sustained a work related injury on 03/13/2015. The medical records provided indicate the diagnosis of Spondylolisthesis, lumbar; Stenosis, Lumbar; Degenerative disc disease, Lumbar; Herniated disc, lumbar; Spondylolisthesis, degenerative-Acquired. Treatment to date has included physical therapy and medications. The medical records provided for review do not indicate a medical necessity for Consultation with a psychiatric specialist. According to the Utilization review report (the providers note with the request was not available for review) the reason for this referral was because the injured worker recently developed depression and anxiety. The provider's records of 06/2015 indicate the injured worker did not have anxiety and depression at the time of the visit; therefore, these symptoms are less than 4 weeks. The MTUS recommends serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, be referred to a specialist after symptoms continue for more than six to eight weeks and therefore is not medically necessary.

**Consultation with a sleep specialist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM 2nd Edition, chapter 7 page 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 399.

**Decision rationale:** The injured worker sustained a work related injury on 03/13/2015. The medical records provided indicate the diagnosis of Spondylolisthesis, lumbar; Stenosis, Lumbar; Degenerative disc disease, Lumbar; Herniated disc, lumbar; Spondylolisthesis, degenerative-Acquired. Treatment to date has included physical therapy and medications. The medical records provided for review do not indicate a medical necessity for Consultation with a sleep specialist. According to the Utilization review report (the providers note with the request was not available for review) the reason for this referral was because the injured worker recently developed insomnia. The provider's records of 06/2015 indicate the injured worker did not

have insomnia at the time of the visit; therefore, these symptoms are less than 4 weeks. The MTUS recommends serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, are referred to a specialist after symptoms continue for more than six to eight weeks. The MTUS recommends counseling the injured worker on sleep hygiene, avoiding caffeine and other stimulants during near bedtime. Therefore, this request is not medically necessary.

**Short course of chiropractic therapy with adjunctive physiotherapy and chiropractic manipulative therapy 2 x wk x 4 wks. spine and right sacroiliac joint: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

**Decision rationale:** The injured worker sustained a work related injury on 03/13/2015. The medical records provided indicate the diagnosis of Spondylolisthesis, lumbar; Stenosis, Lumbar; Degenerative disc disease, Lumbar; Herniated disc, lumbar; Spondylolisthesis, degenerative- Acquired Treatment to date has included physical therapy and medications. The medical records provided for review do not indicate a medical necessity for Short course of chiropractic therapy with adjunctive physiotherapy and chiropractic manipulative therapy 2 x wk x 4 wks Spine and right sacroiliac joint. The MTUS recommends a trial of 6 visits over 2 weeks for therapeutic care of low back musculoskeletal condition; with evidence of objective functional improvement, increase to a total of up to 18 visits over 6-8 weeks. The requested treatment is not medically necessary as it exceeds the guidelines recommendation of 6 trial visits.