

Case Number:	CM15-0069370		
Date Assigned:	04/16/2015	Date of Injury:	12/15/2008
Decision Date:	05/15/2015	UR Denial Date:	03/25/2015
Priority:	Standard	Application Received:	04/13/2015

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, Indiana, New York
Certification(s)/Specialty: Internal 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 is a 48-year-old male who sustained an industrial injury on 12/15/2008. Diagnoses include lumbar sprain/strain, thoracic or lumbar sacral neuritis or radiculitis, displacement of thoracic or lumbar intervertebral disc without myelopathy, stress, anxiety and depression. Treatment to date has included diagnostic studies, and medications. A physician progress note dated 03/02/2015 documents the injured worker complains of lumbar spine pain. He has an infection from in the left stump from a below the knee amputation and an ill fitting prosthetic. He rates his pain as 7 out of 10 with medications and the duration of relief is 1-3 hours. The injured worker uses a wheelchair. He requires assistance with dressing, showering, shopping, household chores and driving. Treatment requested is for replacement of ergonomic chair, and Zanaflex 2mg, #120.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 2mg, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Muscle Relaxants.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Zanaflex 2 mg #120 is not medically necessary. Muscle relaxants are recommended as a second line option short-term (less than two weeks) of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time and prolonged use may lead to dependence. In this case, the injured worker's working diagnoses are lumbosacral spine sprain/strain; facet OA; status post gastric bypass; stress, anxiety and depression deferred. The documentation shows the injured worker was taking Robaxin in a January 6, 2015 progress note. Additionally, Zanaflex 2 mg was first prescribed at that time. In a March 2, 2015 progress note, Zanaflex 2 mg PO TID is still prescribed. Zanaflex is indicated for short-term (less than two weeks) treatment of acute low back pain or an acute exacerbation in chronic low back pain. The treating provider exceeded the recommended guidelines by continuing treatment in excess of three months. Additionally, there is no documentation of an acute exacerbation of chronic low back pain. Consequently, absent compelling clinical documentation in excess of the recommended guidelines for short-term use (less than two weeks), Zanaflex 2 mg #120 is not medically necessary.

Replacement of Ergonomic Chair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 1 Prevention.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Section, Durable Medical Equipment.

Decision rationale: Pursuant to the Official Disability Guidelines, replacement ergonomic chair is not medically necessary. Durable medical equipment is recommended generally if there is a medical need and the device or system meets Medicare's definition of durable medical equipment. Most bathroom and toilet supplies do not customarily serving medical purpose and are primarily used for convenience in the home. The term DME is defined as equipment which: can withstand repeated use; is primarily and customarily served medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in the patient's home. In this case, the injured worker's working diagnoses are lumbosacral spine sprain/strain; facet OA; status post gastric bypass; stress, anxiety and depression deferred. The injured worker's status post left below the knee amputation. The injured worker utilizes an ergonomic chair that presently is unstable and not fit for use. The chair needs to accommodate greater than 300 pounds with adjustable parts for the lumbar spine. The injured worker requires an ergonomic evaluation for the proper ergonomic chair and accessories. Consequently, the replacement ergonomic chair is not medically necessary.