MAXIMUS Federal Services

Case Number:	CM13-0039772		
Date Assigned:	12/20/2013	Date of Injury:	04/28/2008
Decision Date:	05/15/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/09/2013

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 Physical Medicine & Rehabilitation and is licensed to practice in Texas. 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 injured worker is a 47-year-old male who reported an injury on 04/28/2008. The mechanism of injury was not provided. Current diagnoses include bilateral lumbar facet joint pain, central disc protrusion in the lumbar spine, thoracic sprain, and sleep disorder. The injured worker was evaluated on 09/16/2013. The injured worker reported persistent lower back pain. Current medications include Norco 10/325 mg, Soma 350 mg, and Ultram ER 100 mg. Physical examination revealed restricted lumbar range of motion, tenderness to palpation, positive discogenic provocative maneuvers and 5/5 motor strength in the bilateral lower extremities. Treatment recommendations included TENS unit supplies and continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS UNIT SUPPLIES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION) Page(s).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: The MTUS Chronic Pain Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based trial may be considered as a non-invasive conservative option. There is no documentation in the medical records provided for review of how often the TENS unit is used, as well as outcomes in terms of pain relief and function. Therefore, ongoing treatment cannot be determined as medically appropriate. The current request does not specify the type of supplies required or the quantity. Therefore, the request is not medically necessary and appropriate.

PRESCRIPTION FOR NORCO 10/325MG #120 WITH 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The MTUS Chronic Pain Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized this medication since 01/2013. Despite ongoing use, the injured worker continues to report persistent pain. There is no change in the injured worker's physical examination that would indicate functional improvement. Therefore, the request is not medically necessary and appropriate.

PRESCRIPTION FOR ULTRAM ER 100MG #60 WITH 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The MTUS Chronic Pain Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized this medication since 01/2013. Despite ongoing use, the injured worker continues to report persistent pain. There is no change in the injured worker's physical examination that would indicate functional improvement. Therefore, the request is not medically necessary and appropriate.

PRESCRIPTION FOR SOMA 350MG #90 WITH 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL (SOMA) Page(s): 29, 65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66, 124.

Decision rationale: The MTUS Chronic Pain Guidelines state muscle relaxants are recommended as non-sedating second-line options for short-term treatment of acute exacerbations. Soma should not be used for longer than 2 to 3 weeks. The injured worker has utilized this medication since 01/2013. Despite ongoing use, the injured worker continues to report persistent symptoms. There is no documentation of palpable muscle spasm or spasticity upon physical examination. Guidelines do not recommend long-term use of this medication. Therefore, the request is not medically necessary and appropriate.