

Case Number:	CM13-0040008		
Date Assigned:	12/20/2013	Date of Injury:	11/16/2010
Decision Date:	03/27/2014	UR Denial Date:	09/12/2013
Priority:	Standard	Application Received:	10/07/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and 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 physician 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 patient is a 40-year-old female who reported an injury on 11/16/2010. The mechanism of injury was not specifically stated. The patient was seen by [REDACTED] on 08/05/2013. The patient reported significant improvement in symptoms following acupuncture treatment. Physical examination revealed mild tenderness to palpation with positive straight leg raising on the right. The patient is diagnosed as status post L4-5 right sided microdiscectomy on 12/13/2012. Treatment recommendations included a refill of medications including Ambien, Flexeril, naproxen, and Norco, as well as an H-wave home device.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-Wave Device x 1 month evaluation.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 9th Edition (web), H-Wave Stimulation, pg 117.

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

Decision rationale: California MTUS Guidelines state H-wave stimulation is not recommended as an isolated intervention, but a 1 month home based trial may be considered as a noninvasive

conservative option for diabetic neuropathic pain or chronic soft tissue inflammation. As per the documentation submitted, there is no evidence of a failure to respond to physical therapy, medications, and TENS therapy. There is also no documentation of a treatment plan including the specific short and long-term goals of treatment with the H-wave stimulation device. Based on the clinical information received, the request is non-certified.

Ambien 10mg at bedtime #30, refills 1, QTY 60.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 6th Edition, (web), 2008, Pain - Zolpidem - Ambien.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset. There is no documentation of chronic insomnia or sleep disturbance. The patient has continuously utilized this medication. There is no evidence of a failure to respond to nonpharmacological treatment. As guidelines do not recommend long-term use of this medication, the current request is not medically appropriate. Therefore, the request is non-certified.

Flexeril 10mg twice a day # 60, 1 refill, QTY 120.: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on Muscle Relaxants. Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as a non-sedating second line option for short-term treatment of acute exacerbation in patients with chronic low back pain. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. As per the documentation submitted, the patient has continuously utilized this medication. There is no evidence of palpable muscle spasm, spasticity, or muscle tension upon physical examination. As guidelines do not recommend long-term use of this medication, the current request is not medically appropriate. Therefore, the request is non-certified.

Norco 10/325mg twice a day #60, refills 1, QTY 120.: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: California MTUS 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 patient has continuously utilized this medication. There is no documentation of a failure to respond to non-opioid analgesics. The patient's physical examination only revealed mild tenderness to palpation. There is no evidence of a significant musculoskeletal or neurological deficit that would require ongoing opioid therapy. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.