

Case Number:	CM13-0066719		
Date Assigned:	01/03/2014	Date of Injury:	06/20/2013
Decision Date:	05/20/2014	UR Denial Date:	12/04/2013
Priority:	Standard	Application Received:	12/17/2013

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 Internal Medicine, has a subspecialty in Pulmonary Diseases and is licensed to practice in California. 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 43-year-old female who reported an injury on 06/20/2013. The mechanism of injury was not stated. Current diagnoses include lumbar spine strain, lumbar spine degenerative disc disease, and lumbar spine disc protrusion. The injured worker was evaluated on 11/19/2013. The injured worker reported persistent lower back pain with radiation to the left lower extremity. Physical examination on that date revealed slightly limited lumbar range of motion. Treatment recommendations included 12 sessions of physical therapy for the lumbar spine, a TENS unit, and prescriptions for naproxen, Protonix, tramadol, and Ambien.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL PHYSICAL THERAPY THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE GUIDELINES Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength,

endurance, function, range of motion, and can alleviate discomfort. Treatment for myalgia and myositis includes 9 to 10 visits over 8 weeks. Treatment for neuralgia, neuritis, and radiculitis includes 8 to 10 visits over 4 weeks. The current request for 12 sessions of physical therapy exceeds guideline recommendations. There was also no specific body part listed in the current request. Therefore, the request is non-certified.

TENS UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, CHRONIC PAIN Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

Decision rationale: California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based trial may be considered as a noninvasive conservative option. There should be evidence that other appropriate pain modalities have been tried and failed. As per the documentation submitted, there is no evidence of a successful 1 month trial prior to the request for a purchase. There is also no documentation of a failure to respond to other appropriate pain modalities. There was also no documentation of a treatment plan, including the specific short and long-term goals of treatment with the TENS unit. Based on the aforementioned points, the current request is non-certified.

NAPROXEN 550MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state non-steroidal anti-inflammatory drugs (NSAIDs) are recommended for osteoarthritis at the lowest dose for the shortest period. For acute exacerbations of chronic pain, NSAIDs are recommended as a second-line treatment after acetaminophen. There is no frequency listed in the current request. Therefore, the request is non-certified.

ULTRAM 150MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ULTRAM (TRAMADOL) Page(s): 84.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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. There is no frequency listed in the current request. Therefore, the request is non-certified.

PANTOPRAZOLE 20MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. There is no frequency listed in the current request. Therefore, the request is non-certified.

AMBIEN 5MG #30: 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), ZOLPIDEM.

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 for 7 to 10 days. There is no documentation of chronic insomnia. There is also no evidence of a failure to respond to non-pharmacologic treatment. There is no frequency listed in the current request. Therefore, the request is non-certified.