MAXIMUS Federal Services

Case Number:	CM14-0023887		
Date Assigned:	06/11/2014	Date of Injury:	04/18/2008
Decision Date:	07/18/2014	UR Denial Date:	02/17/2014
Priority:	Standard	Application Received:	02/25/2014

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 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 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 49-year-old male who reported an injury on 04/18/2008. The mechanism of injury was noted to be the injured worker lifting a heavy crate. The injured worker had an evaluation on 01/28/2014. He was noted to have diagnoses of lumbago bilateral with radiculopathy, worse on the left side; status post a 3 level anteroposterior fusion with instrumentation; radiculopathy, left severe; radiculitis, right worse than left; Coccydynia secondary to surgery; bilateral sacroiliac joint arthropathy; bilateral facet joint arthropathy, severe; reactive sleep disturbance; reactive depression; cognitive impairment and GI pathology secondary to anterior fusion. The objective findings indicate the injured worker's functional status had improved somewhat since his last visit. It continued to indicate the injured worker's pain scores were diminished. The injured worker continued to exercise as tolerated and will continue to advocate treatment that will improve the injured worker's function as well as daily activities. The objective findings indicated the injured worker continued to have a positive straight leg raise bilaterally. He had decreased light touch, temperature and vibratory sensation over the right leg from L3-S1. There were diminished deep tendon reflexes in the ankle on the left side. The injured worker demonstrated motor weakness in the left ankle with dorsiflexion at 4+/5 and weakness in the quadriceps and hamstrings at 4+/5 to 5/5. The injured worker's left hip flexor was weak. The injured worker had tenderness over the sacroiliac joints bilaterally, left greater than right, and had a strong positive provocation to specific tests. He had focal tenderness over the facets bilaterally with a positive facet joint provocation bilaterally. There was a decrease in range of motion in the lumbar spine to flexion, extension and lateral rotation and he continued to have significant pain in the trunk with flexion and extension. He had tenderness as well as muscle spasms from approximately T5-12 in the right paraspinous area and generally the patient had widespread spasms and trigger point areas throughout the mid back and

low back. The treatment plan included continuing medications, nothing new was added. The provider's rationale for the requested Soma and bupropion was included with the documentation, however, the provider's rationale for the requested TENS unit purchase was not provided within the documentation. The request for authorization for medical treatment was dated 02/11/2014 and submitted with this review. The documentation failed to provided prior treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

SOMA 350 MG #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (SOMA).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carioprodol Page(s): 29.

Decision rationale: The request for Soma 350 mg #180 is non-certified. The California MTUS Chronic Pain Medical Treatment Guidelines indicate Soma is not recommended. This medication is not indicated for long term use. Soma is a commonly prescribed, central acting skeletal muscle relaxant. Soma is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. The documents provided for the review indicate a long term use of Soma, but failed to provide any efficacy and the request does not indicate a frequency of Soma. Soma is not recommended by the guidelines. Therefore, the request for Soma 350 mg #180 is not medically necessary and appropriate.

BUPROPRION: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13.

Decision rationale: Buproprion is an antidepressant also labeled Wellbutrin. The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines indicate antidepressants for chronic pain is recommended as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. Tricyclic's are generally considered a first line agent unless they are ineffective, poorly tolerated or contraindicated. Analgesia usually occurs within a few days to a week, whereas an antidepressant effect takes longer to occur. The assessment of treatment efficacy should include not only pain outcomes but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration and psychological assessment. Side effects including excessive sedation should be assessed. It is recommended that these outcome measurements should be initiated at 1 week of treatment with a recommended trial of at least 4 weeks. The optimal duration of treatment is not known because

most double blind trials have been short of duration. It has been suggested that if pain is in remission for 3 to 6 months a gradual tapering of the antidepressants may be undertaken. The long term effectiveness of antidepressants has not been established. The injured worker had a clinical evaluation on 01/28/2014. That evaluation did not provide an adequate pain assessment. In addition, it did not indicate that the use of antidepressants for chronic pain provided increased function. The documentation did not note any efficacy of buproprion. The request failed to provide a dosage, a frequency and a quantity. Therefore, the request for buproprion is not medically necessary and appropriate.

TENS UNIT PURCHASE: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines do not recommend TENS as a primary treatment modality for chronic pain. However, a 1 month home based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The clinical evaluation on 01/28/2014 did not indicate a TENS 1 month home based trial in addition to a functional restoration program. The injured worker's pain was not assessed adequately to indicate a need for a TENS program. The request did not indicate a duration or a frequency for the TENS unit purchase. Therefore, the request for Tens Unit purchase is not medically necessary and appropriate.