

Case Number:	CM14-0043582		
Date Assigned:	07/11/2014	Date of Injury:	07/13/1995
Decision Date:	08/26/2014	UR Denial Date:	03/18/2014
Priority:	Standard	Application Received:	04/10/2014

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 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 55-year-old male who reported an injury on 07/13/1995. The mechanism of injury was not provided for clinical review. The diagnoses included status post lumbar fusion, chronic low back pain, bilateral knee osteoarthritis, status post bilateral knee arthroscopy, and bilateral SI joint dysfunction, left greater than right. Previous treatments included medication and surgeries. The previous surgeries included a lumbar fusion and bilateral knee arthroscopy. Within the clinical note dated 03/07/2014, it was reported the injured worker complained of chronic low back pain. The injured worker complained of chronic bilateral knee pain. Upon physical examination of the bilateral knees, the provider noted the injured worker had positive patellofemoral crepitation, positive Apley's grind, and healed surgical scar. Upon exam of the lumbar spine, the provider noted spasms, and painful range of motion as well as limited range of motion. The injured worker had a positive Lasegue bilaterally. The provider noted a positive straight leg raise bilaterally to 45 degrees. The injured worker had motor weakness bilaterally at 3/5 to 4/5. The provider requested Ultram, transcutaneous electrical muscle stimulation unit, and Klonopin. However, a rationale was not provided for clinical review. The request for authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Klonopin 1mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The injured worker complained of chronic low back pain, and chronic bilateral knee pain. The California MTUS Guidelines do not recommend Klonopin for long-term use because long-term efficacy is unproven and there is risk of dependence. The guidelines also note limited use of Clonazepam to 4 weeks. The injured worker has been utilizing the medication since at least 09/2012 which exceeds the guideline recommendations of 4 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Ultram 50mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The injured worker complained of chronic low back pain, and chronic bilateral knee pain. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, and side effects. The guidelines recommend the use of urine drug screen for inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. The request submitted failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not provided in the documentation submitted. Therefore, the request is not medically necessary.

Transcutaneous electrical neurostimulation/electrical muscle stimulation (TENS/EMS)

unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

Decision rationale: The injured worker complained of chronic low back pain, and chronic bilateral knee pain. The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A one month home-based TENS trial may be considered a non-invasive conservative option, if used as an adjunct to a program of evidence based functional

restoration. There is evidence that other appropriate pain modalities have been tried including medication and failed. There is lack of documentation indicating significant deficits upon the physical examination. The injured worker's previous course of conservative care was not provided for clinical review. There is lack of documentation indicating if the injured worker has undergone an adequate trial of a TENS unit. The request submitted failed to provide whether the provider is requesting the TENS unit for purchase or rental. Therefore, the request is not medically necessary.