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| Case Number: | CM14-0081459 | | |
| Date Assigned: | 07/18/2014 | Date of Injury: | 07/08/2003 |
| Decision Date: | 09/11/2014 | UR Denial Date: | 05/20/2014 |
| Priority: | Standard | Application Received: | 06/02/2014 |

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 Occupational Medicine, has a subspecialty in Pain Med and Manipulation 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 patient is a 43 year old male with a date of injury on 7/8/03 to the lumbar spine. He is status post lumbar fusion and hardware removal in 2006. He is not working. He was seen on 5/9/14 for lumbar pain. He continues to have persistent pain and dysfunction. He has had temporary response with previous gluteal bursa injections. He has episodic radiating leg pain that is chronic and unchanged. He continues to require 3 Norco a day and 3 Soma a day. He has intolerance to NSAIDs. Exam reveals steady gait, continued tenderness in the left greater than left gluteal burs region with some radiation to the buttock, negative SLR and no focal weakness in the lower extremities. Impression is persistent mechanical lumbar pain/gluteal bursitis, approximately 8 years status post spinal fusion with subsequent hardware removal. Request is made for Tens unit with pad as he previously had significant benefit with this. Norco 10/325 and Soma were refilled. UR on 5/20/14 denied the request for Norco and Tens unit. The prior peer reviewer noted that there is no documentation of a return to work or other functional improvement attributable to ongoing opioid use. It was also noted that UR modified Norco 10/325 mg #40 on 11/17/13 to assist in weaning. In regards to Tens unit, the prior peer reviewer noted that although the patient has reported subjective improvement from prior Tens unit, no functional improvement resulted, the patient did not return to work or terminate opioid use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10mg/325mg, quantity 540.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Opioids Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74 to 96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Opioids for chronic pain.

Decision rationale: The request for Norco is not medically necessary. The guidelines do not recommend chronic use of opioids for chronic non-malignant pain. The guidelines also state that opioids are rarely beneficial for mechanical and compressive etiologies. Furthermore, long term use of opioids leads to tolerance and habituation. Long term use of opioids also leads to testosterone imbalance in men. In this case, despite long term use of opioids, there is no indication of improvement in function or return to work. It should also be pointed out that the patient is also on Soma which in addition to Norco increases sedation and leads to adverse effects. The records indicate that prior modification has been allowed for weaning. For these reasons, the request for Norco 10/325 mg #540 is not medically necessary.

Purchase of a transcutaneous electrical nerve stimulating (TENS) unit with pads for home use.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines: Chronic pain transcutaneous electrical nerve stimulating unit (TENS) Page(s): 114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 113 to 116.

Decision rationale: The request for Tens unit is not medically necessary. The CA MTUS guidelines indicate that Tens unit made be indicated for Neuropathic pain, Phantom limb pain and CRPS II, Spasticity, and Multiple sclerosis (MS). The patient is not diagnosed with conditions that support the use of this DME unit. In addition, the guidelines do not support the use of Tens unit for chronic low back pain. As noted in ODG, A recent meta-analysis concluded that the evidence from the small number of placebo-controlled trials does not support the use of TENS in the routine management of chronic LBP. There was conflicting evidence about whether TENS was beneficial in reducing back pain intensity and consistent evidence that it did not improve back-specific functional status. There was moderate evidence that work status and the use of medical services did not change with treatment. Patients treated with acupuncture-like TENS responded similarly to those treated with conventional TENS. (Khadilkar-Cochrane, 2008). In addition, while the patient has reported improvement from prior use of Tens unit, there is no evidence of objective functional improvement or decrease in medication use obtained from prior use of Tens unit to support the request for a purchase.