

Case Number:	CM14-0195858		
Date Assigned:	12/03/2014	Date of Injury:	08/24/2014
Decision Date:	01/20/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	11/21/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine 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:

This is a patient with a date of injury of 8/24/12 to 8/24/14. A utilization review determination dated 11/5/14, recommends non-certification of Ultram ER, Fexmid, Ativan, lumbosacral orthosis, and interferential unit. On 10/24/14 doctor's first report, identifies low back pain radiating to the bilateral lower extremities (BLE). On exam, there is tenderness, SI stress test is positive bilaterally as is straight leg raises (SLR). The range of motion (ROM) was limited. Sensation in the BLE is decreased in a patchy distribution. Recommendations include chiropractic, LSO, IF unit, Ultram ER, Fexmid, and Ativan for sleep.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram ER 150mg #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Ultram ER, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side

effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, this appears to be a new prescription. The patient does have low back pain with positive exam findings. A short course of opioids is appropriate in the management of pain; therefore, this request is medically necessary.

Fexmid 7.5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 63-66 of 127.

Decision rationale: Regarding the request for Fexmid, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of recent muscle spasms and the medication is a sedating muscle relaxant. Additionally, there is no documentation that the patient has failed first line agents. In light of the above issues, this request is not medically necessary.

Ativan (Lorazepam 2mg) #30: Upheld

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

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

Decision rationale: Regarding the request for Ativan, CA MTUS does not address benzodiazepines for insomnia. Official Disability Guidelines (ODG) recommended the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is no clear description of insomnia and no statement indicating what behavioral treatments have been attempted for the condition of insomnia. In the absence of such documentation, this request is not medically necessary.

DME purchase: Lumbosacral orthosis: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: Regarding the request for lumbosacral orthosis, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Within the documentation available for review, the patient is well beyond the acute stage of injury. In addition, there is no documentation of a pending/recent spine surgery, spinal instability, compression fracture, or another clear rationale for a brace in the management of this patient's chronic injury. In the absence of such documentation, this request is not medically necessary.

DME purchase: Interferential unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 118-120 of 127.

Decision rationale: Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation as outlined above. Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, this request is not medically necessary.