

Case Number:	CM14-0209001		
Date Assigned:	12/22/2014	Date of Injury:	07/31/2003
Decision Date:	02/25/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/15/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient is a 57 year-old female with date of injury 07/31/2003. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 11/03/2014, lists subjective complaints as pain in the low back with radicular symptoms down the right lower extremity. Objective findings: Examination of the lumbar spine revealed significant tenderness to palpation. Lumbar spine testing showed normal range of motion in flexion, extension, lateral flexion, and rotation. Decreased sensation in the right S1 dermatome. Motor examination was within normal limits. Diagnosis: 1. Chronic lower back pain with clinical radicular symptoms on the left. 2. Chronic neck pain with clinical radicular symptoms on the left. 3. Chronic abdominal pain- non-industrial. Original reviewer modified medication request to Restoril 15mg, #25. The medical records supplied for review document that the patient was first prescribed the following medication on 11/03/2014. Prior to the request, the patient had been taking Ambien since at least as far back as January, 2014. Medication: 1. Restoril 15mg, #30 SIG: 1 qhs.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS Unit - DME Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 2009, Pain - TENS.

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

Decision rationale: The MTUS does not recommend a TENS unit as a primary treatment modality, but a one-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. There is no documentation that a trial period with a rented TENS unit has been completed. Purchase of a TENS unit is not medically necessary. TENS Unit - DME Purchase is not medically necessary.

Restoril 15mg QTY: 25.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain - Benzodiazepine Page(s): 24.

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

Decision rationale: The Official Disability Guidelines do not recommended benzodiazepines such as Restoril for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks. The patient has been given Restoril in place of Ambien. The previous evaluator provided a weaning dose of Restoril. The request is not medically necessary.