MAXIMUS Federal Services

Case Number:	CM15-0000680		
Date Assigned:	01/13/2015	Date of Injury:	03/04/2012
Decision Date:	03/13/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	01/02/2015

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: Physical Medicine & Rehabilitation

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 34-year-old male who reported injury on 03/04/2012. The mechanism of injury was repetitive lifting, stacking and organizing of boxes. The documentation of 11/25/2014 revealed the injured worker utilized acupuncture and physical therapy. The injured worker had complaints of constant pain in his low back radiating to his bilateral lower extremities. The injured worker indicated his pain was managed with Norco 1 to 2 per day. The medical history included GERD. The medications included 1 to 2 per day of Norco 5/325, Lialda 1.2 gm 2 times a day, paroxetine 20 mg, Advair and Pepcid. The physical examination revealed there positive was tenderness to palpation in the lower lumbar spine and bilateral paraspinous muscles and tenderness to palpation in the bilateral SI joints. There was positive faber bilaterally. There was decreased sensation grossly to light touch at L3 and L4 on the left and S1 on the right. Range of motion was limited secondary to pain. The injured worker had positive straight leg raise bilaterally. The diagnoses included lumbar degenerative disc disease, thoracic or lumbosacral neuritis or radiculitis unspecified and sacroiliac ligament sprain and strain. The treatment plan included hydrocodone 5/325 mg twice a day as needed for pain and TENS patches times 2, as well as depression screening. The documentation indicated the injured worker had more benefit from a psychiatrist than psychologist in the past. The documentation indicated the injured worker's injury increased the frequency of his pre-existing anxiety. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS patch, quantity 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 116.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend TENS unit as an adjunct to a functional restoration program. The documentation indicated the injured worker had previously utilized a TENS unit and was in need of patches. There was a lack of documentation objective functional benefit and objective pain relief that was received from the TENS unit. As such, this request would not be supported. Given the above, the request for TENS patch quantity is not medically necessary.

Hydrocodone 5 mg # 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, Ongoing management Page(s): 60; 78.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional benefit, an objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to indicate the injured worker was being monitored for aberrant drug behavior and side effects. There was a lack of documentation of objective functional benefit and an objective decrease in pain. The request, as submitted, failed to indicate the frequently for the requested medication. Given the above, the request for hydrocodone 5 mg #60 is not medically necessary.

Depression Screening: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations Page(s): 100.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that psychological evaluates are accepted and diagnostic evaluates should distinguish between conditions that are pre-existing or aggravated by the current injury or are work related. The

clinical documentation submitted for review indicated the injured worker had previously undergone therapy with a psychologist and psychiatrist. There was a lack of documentation indicating a necessity for a new screening. Additionally, the request as submitted failed to indicate the specific testing being requested. Given the above, the request for depression screening is not medically necessary.