

<b>Case Number:</b>	CM15-0008007		
<b>Date Assigned:</b>	01/23/2015	<b>Date of Injury:</b>	05/31/2002
<b>Decision Date:</b>	03/13/2015	<b>UR Denial Date:</b>	01/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/14/2015

### 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 43 year old male who sustained an industrial related injury on 7/29/14. The injured worker had complaints of low back pain and difficulty sleeping. Physical examination revealed the left shoulder impingement sign was positive, the anterior shoulder was tender to palpation, and range of motion was restricted. Lumbar paravertebral muscles were tender to palpation, spasms were present, and range of motion was restricted. Diagnoses included bilateral shoulder impingement, lumbar radiculopathy, and recurrent dislocation of shoulder, anxiety disorder, sleep arousal disorder, intestinal malabsorption, brachial neuritis or radiculitis, and enthesopathy of the wrist. The treating physician requested authorization for chiropractic therapy 3x4 for the neck, low back, and bilateral upper extremities, Hydrocodone 10/325mg #120 with 2 refills, Carisoprodol 350mg #60 with 2 refills, Zolpidem 10mg #30, and a TENS unit. On 1/13/15 the requests were non-certified. The request for Carisoprodol 350mg #60 with 2 refills and Zolpidem 10mg #30 was modified. Regarding chiropractic therapy, the utilization review (UR) physician cited the Medical Treatment Utilization Schedule (MTUS) guidelines and noted elective/maintenance care was not medically necessary. Regarding Hydrocodone, the UR physician cited the MTUS guidelines and noted there was insufficient documentation of a diagnosis or functional goals to support ongoing opioid treatment. Regarding Carisoprodol, the UR physician cited the MTUS guidelines and noted the medication was not indicated for long term use and not recommended in combination with Hydrocodone. The request was modified for weaning purposes. Regarding Zolpidem, the UR physician cited Official Disability Guidelines and noted the medication is recommended for short term use only.

and the medical records did not provide a rationale for ongoing use of this medication. Regarding a TENS unit, the UR physician cited the MTUS guidelines and noted the medical records did not indicate if the TENS unit was requested for neuropathic pain. It was also not clear how the TENS unit would be part of overall functional goals. Therefore the request was non-certified.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Chiropractic therapy 3 x wk x 4 wks for the neck, low back and bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic Care, Manual Therapy & Manipulation, Treatment, Pages 58-60.

**Decision rationale:** MTUS Guidelines supports chiropractic manipulation for musculoskeletal injury. It is unclear how many sessions have been completed to date. Submitted reports have not demonstrated clear specific functional benefit or change in chronic symptoms and clinical findings for this chronic injury. There are unchanged clinical findings and functional improvement in terms of decreased pharmacological dosing with pain relief, decreased medical utilization, increased ADLs or improved work/functional status from treatment already rendered by previous chiropractic care. Clinical exam remains unchanged without acute flare-up or new red-flag findings. It appears the patient has received an extensive conservative treatment trial; however, remains unchanged without functional restoration approach. The Chiropractic therapy 3 x wk x 4 wks for the neck, low back and bilateral upper extremities is not medically necessary and appropriate.

**Hydrocodone 10/325mg # 120 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, page(s) 74-96.

**Decision rationale:** Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in

medical utilization or change in functional status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain for this chronic injury without acute flare, new injury, or progressive deterioration. The Hydrocodone 10/325mg # 120 with 2 refills is not medically necessary and appropriate.

**Carisoprodol 350mg #60 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma), page 29.

**Decision rationale:** Per MTUS Chronic Pain Guidelines on muscle relaxant, Soma is not recommended for mild to moderate chronic persistent pain problems including chronic pain (other than for acute exacerbations) due to the high prevalence of adverse effects in the context of insufficient evidence of benefit as compared to other medications. Guidelines do not recommend long-term use of this muscle relaxant for this chronic injury. Additionally, the efficacy in clinical trials has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Submitted reports have not adequately demonstrated the indication or medical need for this treatment and there is no report of significant clinical findings, acute flare-up or new injury to support for its long-term use. There is no report of functional improvement resulting from its previous treatment to support further use as the patient remains unchanged. The Carisoprodol 350mg #60 with 2 refills is not medically necessary and appropriate.

**Zolpidem 10mg # 30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chapter- Pain

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Zolpidem (Ambien®), pages 877-878

**Decision rationale:** Per the ODG, this non-benzodiazepines CNS depressant should not be used for prolonged periods of time and is the treatment of choice in very few conditions. The tolerance to hypnotic effects develops rapidly with anxiolytic effects occurring within months; limiting its use to 4 weeks as long-term use may actually increase anxiety. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern

that they may increase pain and depression over the long-term. Submitted reports have not identified any clinical findings or specific sleep issues such as number of hours of sleep, difficulty getting to sleep or staying asleep or how the use of this sedative/hypnotic has provided any functional improvement if any from treatment rendered. The reports have not demonstrated any clinical findings or confirmed diagnoses of sleep disorders to support its use for this chronic injury. There is no failed trial of behavioral interventions or proper pain management as the patient continues on opiates with stated pain relief to hinder any sleep issues. The Zolpidem 10mg # 30 is not medically necessary and appropriate.

**TENS Unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain, pages 114-117.

**Decision rationale:** Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, the patient has chronic low back condition and has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive therapy, activity modifications, yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, whether this is for rental or purchase, nor is there any documented short-term or long-term goals of treatment with the TENS unit. Although the patient has utilized the TENS unit for several months, there is no evidence for change in work status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the TENS treatment already rendered. The TENS Unit is not medically necessary and appropriate.