MAXIMUS Federal Services

Case Number:	CM15-0192781		
Date Assigned:	10/06/2015	Date of Injury:	03/28/2011
Decision Date:	11/19/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/30/2015

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, Hawaii
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 36 year old male, who sustained an industrial injury on 3-28-2011. He reported injury to the left hand and low back. Diagnoses include lumbar facet syndrome, low back pain, and hand pain. Treatments to date include activity modification, medication therapy, physical therapy, acupuncture treatments, lumbar epidural steroid injections, medical branch blocks, and radiofrequency ablation. On 9-1-15, he reported ongoing low back and left upper extremity pain. The pain was rated 8 out of 10 VAS. The provider documented the H-wave "is working well reducing pain to 3 out of 10 VAS for about three hours." The record further documented that the injured worker had been approved for an H-wave unit with 8 H-wave pads, used daily for at least 45 minutes with greater than 50% reduction in low back pain with 2-3 hours relief afterwards. It was further noted that it reduced neuropathic pain by 100% for a couple hours and helped with sleep. Current medications listed included Oxycodone HCL 5 mg tablet, half to full tablet daily as needed, Omeprazole daily, Lidoderm Patch 12 hours per day as needed, and Zanaflex. The records documented that Omeprazole and Oxycodone HCL were prescribed since at least 9-22-14. The physical examination documented tenderness in lumbar muscles and spinal process on L5 with restricted range of motion due to pain. The lumbar facet loading test was positive. The left elbow was tender over the epicondyle and Tinel's sign was positive. The right hip demonstrated a positive Thigh thrust, compression test, Gaenslen's test and Faber test. There was decreased strength and decreased sensation noted in lower extremities. The plan of care included continuing Oxycodone for breakthrough pain and Omeprazole for gastrointestinal upset, and ongoing H-wave therapy. The appeal requested authorization for H-

wave treatment, Oxycodone HCL 5mg #30, and Omeprazole DR 20mg #30 with two additional refills. The Utilization Review dated 9-14-15, denied this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

One H-wave: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The patient presents with pain affecting the low back and left upper extremity. The current request is for One H-wave. The treating physician report dated 9/29/15 (17C) states, request 8 additional H wave pads. Approved 8 H wave pads "patient received H-wave and it is reducing his pain to 3/10." The MTUS guidelines regarding H-Wave devices page 117 state a 30 trail may be recommended and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). In this case, the patient has already received an H-wave device and there is no documentation provided as to why the patient would require an additional H-wave device. Furthermore, there is no evidence of a 30-day trial or failure of a TENS unit as required by the MTUS guidelines. The current request is not medically necessary.

Oxycodone HCL 5mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The patient presents with pain affecting the low back and left upper extremity. The current request is for Oxycodone HCL 5mg #30. The treating physician report dated 9/29/15 (17C) states, "The patient currently has adequate and appropriate Analgesia medications with functional benefit and improved quality of life." MTUS pages 88 and 89 states "document pain and functional improvement and compare to baseline. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS also requires documentation of the four A's (analgesia, ADL's, Adverse effects and Adverse behavior). The report dated 9/29/15 (7C) notes that the patient's pain decreased from 9/10 to 3-4/10 while on current medication. No adverse effects or adverse behavior were noted by patient. The patient's ADL's have improved such as the ability to care

for himself, and take care of any household tasks. The patient's last urine drug screen was consistent and the physician has a signed pain agreement, and CURES report on file as well. The continued use of Oxycodone has improved the patient's symptoms and have allowed the patient to enjoy a greater quality of life. In this case, all four of the required A's are addressed, the patients pain level has been monitored upon each visit and functional improvement has been documented. The current request is medically necessary.

Omeprazole DR 20mg #30 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation University of Michigan Health System. Gastroesophageal reflux disease (GERD). Ann Arbor (MI): University of Michigan Health System; 2007 Jan 10p.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The patient presents with pain affecting the low back and left upper extremity. The current request is for Omeprazole DR 20mg #30 with 2 refills. The treating physician report dated 9/29/15 (15C) states, "GI upset managed with Omeprazole." The MTUS guidelines state Omeprazole is recommended with precautions, "(1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." Clinician should weigh indications for NSAIDs against GI and cardio vascular risk factors, determining if the patient is at risk for gastrointestinal events. In this case, while the treating physician does state, "GI upset managed with Omeprazole," there was no documentation provided of any current NSAID use nor was there any documentation of a risk assessment being performed. The current request does not satisfy MTUS guidelines as outlined on pages 68-69. The current request is not medically necessary.