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| Case Number: | CM15-0199398 | | |
| Date Assigned: | 10/14/2015 | Date of Injury: | 11/16/1995 |
| Decision Date: | 12/17/2015 | UR Denial Date: | 09/17/2015 |
| Priority: | Standard | Application Received: | 10/09/2015 |

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: 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:

The injured worker is a 56 year old male, who sustained an industrial injury on 11-16-1995. The injured worker was being treated for failed laminotomy pain syndrome, status post L5-S1 interbody fusion at L5-S1 in 2-2002, chronic right lower extremity atrophy with weakness, severe bilateral hip osteoarthritis, left knee degenerative disease, diverticulitis, depression and daily alcohol use. Treatment to date has included diagnostics, lumbar spinal surgery in 2002, physical therapy, mental health treatment, and medications. Currently (9-08-2015), the injured worker complains of "widespread severe pain", not rated, on a "stable analgesic regimen". Work status was "per PTP". Current function with activities of daily living was not described. Exam noted a labored and cane assisted gait, slow movement with obvious pain, positive straight leg raise bilaterally, right leg atrophy, and audible crepitus in both hips and the left knee. The use of Norco (since at least 12-2014), transcutaneous electrical nerve stimulation unit, and H wave unit was referenced in the progress report dated 5-05-2015, along with a plan to trial Robaxin (noting previous use of Soma). Urine toxicology reports (5-05-2015 and 7-28-2015) were inconsistent with prescribed medication (positive Amitriptyline). The treating physician documented that he should continue use with transcutaneous electrical nerve stimulation and H wave, noting "helped patient pain and remain on a low medication dosage". It was not clear when previous liver function tests were completed or what the results were. The treatment plan included Robaxin 750mg #90, Norco 10mg #30, 1 liver function tests, 1 transcutaneous electrical nerve stimulation unit with supplies, and 1 H wave unit with supplies, non-certified by Utilization Review on 9-17-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Robaxin 750mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The MTUS states that muscle relaxants are recommended with caution only on a short-term basis. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The patient had previously been taking the muscle relaxant Soma for an extended period of time; far longer than the short-term course recommended by the MTUS. There was no functional improvement demonstrated in the records. 1 prescription of Robaxin 750mg #90 is not medically necessary.

1 prescription of Norco 10mg #30: 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): Opioids for chronic pain.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. 1 prescription of Norco 10mg #30 is not medically necessary.

1 liver function test: 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. managing chronic non-terminal pain in adults including prescribing controlled substances. Ann Arbor (MI) University of Michigan Health System; 2011 Jan. 36p.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, specific drug list & adverse effects.

Decision rationale: According to the MTUS, the package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests).

There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. The requested test is not listed as recommended to monitor a patient on the current drug regimen and there is no documentation in the medical record that the laboratory studies were to be used for any of the above indications. One liver function test is not medically necessary.

1 TENS unit with supplies: Overturned

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 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 documentation that the patient meets the criteria necessary for TENS unit purchase following a successful one-month trial of a rental TENS unit. I am reversing the previous utilization review decision. 1 TENS unit with supplies is medically necessary.

1 H-Wave unit with supplies: 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 MTUS does not recommended H-wave stimulators as an isolated intervention. There is no evidence that H-Wave is more effective as an initial treatment when compared to TENS for analgesic effects. A randomized controlled trial comparing analgesic effects of H-wave therapy and TENS on pain threshold found that there were no differences between the different modalities or HWT frequencies. The patient has already been approved for a TENS unit. 1 H-Wave unit with supplies is not medically necessary.