

Case Number:	CM15-0209010		
Date Assigned:	10/28/2015	Date of Injury:	10/22/2004
Decision Date:	12/08/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/23/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 76 year old female, who sustained an industrial injury on 10-22-04. Medical records indicate that the injured worker is undergoing treatment for lumbar radiculopathy and lumbar herniated disc. The injured worker is currently not working. On (8-29-15, 7-30-15 and 5-30-15) the injured worker complained of low back pain which radiated down the bilateral lower extremities with associated numbness and tingling. The pain is aggravated by bending and twisting movements. The pain is better with medications and a lumbar support. The injured worker also noted that a transcutaneous electrical nerve stimulation unit has been helpful in the past. Examination of the lumbar spine revealed tenderness to palpation over the lumbar paraspinal muscles. Range of motion was decreased due to pain and stiffness. A straight leg raise test was positive bilaterally. Sensation was diminished to light touch and pinprick in the bilateral lumbar five-sacral one distribution. Pain levels were not provided. Treatment and evaluation to date has included medications, urine drug screen (8-29-15), back support and a transcutaneous electrical nerve stimulation unit. Current medications include Norco (since at least February of 2015). The Request for Authorization dated 8-29-15 included requests for retrospective Norco 10-325mg #90 and retrospective transcutaneous electrical nerve stimulation unit with replacement batteries and supplies. The Utilization Review documentation dated 9-30-15 non-certified the requests for the retrospective Norco 10-325mg #90 and retrospective transcutaneous electrical nerve stimulation unit with replacement batteries and supplies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Norco 10/325 MG #90: Upheld

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

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

Decision rationale: The California MTUS states: When to Continue Opioids: (a) If the patient has returned to work (b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004). The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function or activity specifically due to the medication. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.

Retro TENS Unit with Replacement Batteries and Supplies: Upheld

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

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

Decision rationale: The California chronic pain medical treatment guidelines section on transcutaneous electrical nerve stimulation states: TENS, chronic pain (transcutaneous electrical nerve stimulation) - Not recommended 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, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. (Carroll-Cochrane, 2001) Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. One problem with current studies is that many only evaluated single-dose treatment, which may not reflect the use of this modality in a clinical setting. Other problems include statistical methodology, small sample size, influence of placebo effect, and difficulty comparing the different outcomes that were measured. This treatment option is recommended as an adjunct to a program of evidence based functional restoration. In addition there must be a 30 day trial with objective measurements of improvement. These criteria have not been met in the review of the provided clinical documentation and the request is not medically necessary.