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| Case Number: | CM15-0051768 | | |
| Date Assigned: | 04/14/2015 | Date of Injury: | 11/21/2003 |
| Decision Date: | 06/01/2015 | UR Denial Date: | 03/06/2015 |
| Priority: | Standard | Application Received: | 03/19/2015 |

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 36 year old female, who sustained an industrial injury on November 21, 2003. The injured worker was diagnosed as having spasm of muscle, lumbar spine degenerative disc disease and low back pain. Treatment to date has included diagnostic studies, physical therapy, TENS unit, H-wave, medications and work modifications. The injured worker presented on 02/26/2015 for a follow-up evaluation with complaints of 3/10 pain and poor sleep quality. The current medication regimen includes Lidoderm 5% patch, Ambien CR, Soma, Dilaudid, and Cymbalta. Upon examination there was restricted range of motion of the lumbar spine with flexion limited to 60 degrees and extension to 10 degrees. On palpation, there was paravertebral muscle tenderness on the right, straight leg raising test was negative. Motor strength was 5/5 bilaterally. On sensory examination, light touch sensation was decreased over the anterior thigh, medial thigh, and lateral thigh on the right side. Treatment recommendations included continuation of the current medication regimen, a course of physical therapy for 6 sessions, laboratory studies for liver and kidney function, and H-wave unit supplies. There was no Request For Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 12.5mg #20: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short treatment of insomnia with difficulty of sleep onset for 7 to 10 days. According to the documentation provided, the injured worker has continuously utilized Ambien 12.5 since 08/2014. The injured worker continues to report poor sleep quality. Guidelines do not support long-term use of hypnotics. There is also no frequency listed in the request. As such, the request is not medically necessary.

Soma 350mg tablet #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations. Soma should not be used for longer than 2 to 3 weeks. The injured worker has continuously utilized the above medication since 08/2014. Guidelines would not support long-term use of this medication. There is also no documentation of objective functional improvement. The request as submitted failed to indicate the frequency. Given the above, the request is not medically necessary.

Lidoderm Patch 5% #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 111-113.

Decision rationale: California MTUS Guidelines state lidocaine is indicated for peripheral pain or neuropathic pain after there has been evidence of a trial of first line therapy with tricyclic or SNRI antidepressants or anticonvulsants. In this case, there was no documentation of a failure of first line oral medication. The injured worker has continuously utilized the above medication since 08/2014 without any evidence of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

Physical therapy x 6 sessions to evaluation and treat low back pain: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter <http://www.odg-twc.com/preface.htm#physicaltherapyguidelines>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity and beneficial for restoring flexibility, strength, endurance, function, range of motion and can alleviate discomfort. There was no documentation of objective functional improvement following the initial course of physical therapy with evidence of objective functional improvement. Additional treatment would not be supported. Given the above, the request is not medically necessary.

H Wave Supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: California MTUS Guidelines state H-wave stimulation is not recommended as an isolated intervention, but a 1 month home-based trial of H-wave stimulation may be considered as a non-invasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation. H-wave stimulation should be used as an adjunct to a program of evidence based functional restoration and only following failure of initially recommended conservative care, including physical therapy, medications, and TENS therapy. In this case, there was no documentation of significant functional improvement despite the ongoing treatment with the H-wave device. Additional supplies would not be supported at this time. As such, the request is not medically necessary.