

Case Number:	CM15-0058850		
Date Assigned:	04/03/2015	Date of Injury:	01/05/2012
Decision Date:	05/26/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	03/27/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 female who reported an injury on 01/05/2012. The mechanism of injury was not specifically stated. The current diagnosis is discogenic lumbar condition with radicular component. The injured worker presented on 03/11/2015 for a follow-up evaluation regarding low back pain. Previous conservative treatment includes lumbar bracing, hot/cold therapy, TENS therapy, H-wave stimulation, and medication management. Upon examination, there was tenderness along the lumbosacral area, weakness to resisted flexion and extension, positive facet loading, flexion to 40 degrees, and extension to 15 degrees. Treatment recommendations at that time included continuation of the current medication regimen, as well as a TENS unit. A Request for Authorization form was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Durable medical equipment (DME) transcutaneous electrical nerve stimulation (TENS) unit with conductive garment, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: California MTUS Guidelines do not recommend transcutaneous electrotherapy as a primary treatment modality but a 1-month home based trial may be considered as a noninvasive conservative option. In this case, there was no documentation of a successful 1-month trial prior to the request for a unit purchase. It was noted that the injured worker had access to a back brace, and hot and cold wrap, as well as a TENS unit. It was then noted later in the physician progress note, the injured worker did not have access to a TENS unit. There is conflicting evidence as to whether or not the injured worker currently utilizes a TENS device. Given the above, the request is not medically necessary at this time.

Fenoprofen calcium 400mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. The injured worker has continuously utilized the above medications since 12/2014. Guidelines do not support long-term use of NSAIDs. There is also no documentation of objective functional improvement. As such, the request is not medically necessary.

Pantoprazole sodium 20mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state, proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. Additionally, there is no frequency listed in the request. As such, the request is not medically necessary.

Lidopro cream 121g, #1 bottle: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In this case, there was no documentation of a failure of first line oral medication prior to the initiation of a topical analgesic. There is also no frequency listed in the request. As such, the request is not medically necessary.

Cyclobenzaprine 7.5mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

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. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. There was no documentation of palpable muscle spasm or spasticity upon examination. The injured worker has continuously utilized the above medications since 12/2014. Guidelines would not support long-term use of this medication. There is also no frequency listed in the request. As such, the request is not medically necessary.

Tramadol extended release (ER) 150mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, Tramadol.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized the above medication for an unknown duration. There is no documentation of objective functional improvement. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Trazadone 50mg, #60: 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-TWC), Mental Illness and Stress.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Trazodone.

Decision rationale: The Official Disability Guidelines recommend trazodone as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms, such as depression or anxiety. In this case, the injured worker does not maintain a diagnosis of insomnia, depression, or anxiety. The medical necessity for the requested medication has not been established in this case. There is also no frequency listed in the request. Given the above, the request is not medically necessary.