

Case Number:	CM15-0089084		
Date Assigned:	05/13/2015	Date of Injury:	10/11/2006
Decision Date:	06/12/2015	UR Denial Date:	04/23/2015
Priority:	Standard	Application Received:	05/08/2015

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 64 year old male, who sustained an industrial injury on 10/11/2006. The injured worker is currently disabled. The injured worker is currently diagnosed as having cervical sprain, bilateral impingement syndrome, bilateral wrist inflammation, lumbosacral sprain, internal derangement of the left knee, ring finger stenosing tenosynovitis, chronic pain syndrome, and depression. Treatment and diagnostics to date has included lumbar spine MRI, Transcutaneous Electrical Nerve Stimulation Unit, wrist braces, hot/cold wrap, and medications. In a progress note dated 04/09/2015, the injured worker presented with complaints of neck, left shoulder, and low back pain. Objective findings include tenderness along the left shoulder. The treating physician reported requesting authorization for replacement Transcutaneous Electrical Nerve Stimulation Unit, Avinza, and lumbar spine back support.

IMR ISSUES, DECISIONS AND RATIONALES

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

4 lead TENS unit with conductive garment, left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain, pages 114-117.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, the patient has chronic condition and has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive therapy, activity modifications, and previous TENS trial yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, nor is there any documented short-term or long-term goals of treatment with the TENS unit. Although the patient has utilized the TENS unit for some time, there is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the TENS treatment already rendered. The 4 lead TENS unit with conductive garment, left shoulder is not medically necessary and appropriate.

Avinza 60mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, page(s) page 74-96.

Decision rationale: AVINZA (morphine sulfate extended-release capsules) contain both immediate release and extended release beads of morphine sulfate for once daily oral administration. AVINZA capsules are a modified-release formulation of morphine sulfate intended for once daily administration indicated for the relief of moderate to severe pain requiring continuous, around-the-clock opioid therapy for an extended period of time. Morphine is an opioid agonist and a Schedule II controlled substance. Such drugs are sought by drug abusers and people with addiction disorders. Diversion of Schedule II products is an act subject to criminal penalty. Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e. g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in functional status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would

otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain for this chronic injury without acute flare, new injury, or progressive deterioration. The Avinza 60mg is not medically necessary and appropriate.

Purchase of lumbar spine back support and inserts: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Low Back Chapter 12, page 301.

Decision rationale: There are no presented diagnoses of instability, compression fracture, or spondylolisthesis with spinal precautions to warrant a back brace for chronic low back pain. Reports have not adequately demonstrated the medical indication for the LSO. Based on the information provided and the peer-reviewed, nationally recognized guidelines, the request for an LSO cannot be medically recommended. CA MTUS notes lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. This patient is well beyond the acute phase of this chronic injury. In addition, ODG states that lumbar supports are not recommended for prevention; is under study for treatment of nonspecific LBP; and only recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, or post-operative treatment. Submitted reports have not adequately demonstrated indication or support for the request beyond the guidelines recommendations and criteria. The Purchase of lumbar spine back support and inserts is not medically necessary and appropriate.