

Case Number:	CM14-0217746		
Date Assigned:	01/26/2015	Date of Injury:	11/03/2008
Decision Date:	03/06/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	12/29/2014

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 patient is a 28 year old female with an injury date on 11/03/2008. Based on the 10/21/2014 most recent progress report provided by the treating physician, the diagnoses are: 1. Lumbar discogenic disease. 2. History of Hepatitis C with high liver enzymes. 3. Chronic low back pain. 4. Sleep disturbance. 5. Left lower extremity radiculopathy. According to this report, the patient complains of low back pain; without medication 10/10. With medication 5/10 and can move with medicine. The patient also complains of left leg pain that is unbearable. Physical exam reveals tenderness to palpation diffusely and severe spasm at the lumbar region. Straight leg raise is positive on the left at 60 degrees with radiation to the left lower extremity. Lasegue test is positive. Decreased sensation is noted at the left L5 and S1. Motor strength of the EHL is a 4/5. The examinations findings remains unchanged from the 08/19/2014 and 07/01/2014 reports. The 08/19/2014 report indicates patients pain is a 5/10 with medications and a 10/10 without medications. The treatment plan is to request for LESI, chemistry panel, TENS unit, moist heat pad, and return in 6 weeks for follow up visits. The patients work status is temporarily totally disabled. There were no other significant findings noted on this report. The utilization review denied the request for (1)1 prescription of Oxycodone 10mg#180 and modified to 1 prescription of oxycodone 10mg #84, (2) Anaprox 550mg #60, (3)Prilosec 20mg #60, (4) Neurontin 600mg #30, (5) TENS unit, (6) 1 moist heating pad, and (7)1 chemistry panel on 12/24/2014 based on the MTUS/ODG guidelines. The requesting physician provided treatment reports from 01/07/2014 to 10/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 10 mg # 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
CRITERIA FOR USE OF OPIOIDSMedications for chronic pain Page(s): 60-61,88-89,76-78.

Decision rationale: According to the 10/21/2014 report, this patient presents with 5/10 lower back pain and “unbearable” left leg pain. The current request is for 1 prescription of Oxycodone 10mg#180. This medication was first mentioned in the 01/07/2014 report; it is unknown exactly when the patient initially started taking this medication. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the reports provided by the treating physician show documentation of pain assessment using a numerical scale describing the patient's pain ranging from a 10/10 to a 5/10. However, there is no documentation provided discussing functional improvement, ADL's or returns to work. No aberrant drug seeking behavior is discussed in the records provided. The treating physician has failed to clearly document the 4 A's (analgesia, ADL's, adverse side effects, adverse behavior) as required by MTUS. Therefore, the request IS NOT medically necessary and the patient should be slowly weaned per MTUS.

TENS unit: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Transcutaneous Electrical Nerve Stimulation (TENS).

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

Decision rationale: According to the 10/21/2014 report, this patient presents with 5/10 lower back pain and “unbearable” left leg pain. The current request is for 1 TENS unit. TENS units, the MTUS guidelines state “not recommended as a primary treatment modality, but a one-month home-based unit trial may be considered as a noninvasive conservative option” and may be appropriate for neuropathic pain. The guidelines further state a “rental would be preferred over purchase during this trial.” Review of the provided medical records shows that the patient has neuropathic pain and there is no indication that the patient has trialed a one-month rental. In this case, the requested one month trial of the TENS unit is supported by the MTUS. Therefore, the request IS medically necessary.

1 Moist heating pad: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 162.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation low back chapter, Heat therapy

Decision rationale: According to the 10/21/2014 report, this patient presents with 5/10 lower back pain and “unbearable” left leg pain. The current request is for 1 moist heating pad. Regarding Heating pad, ODG guidelines state “Recommended” combining continuous low-level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with either intervention alone or control. Heat therapy has been found to be helpful for pain reduction and return to normal function. In this case, the treating physician has recommended a moist heating pad and ODG recommends this as an option. Therefore, the request IS medically necessary.