

Case Number:	CM14-0047393		
Date Assigned:	07/02/2014	Date of Injury:	06/28/2009
Decision Date:	06/02/2015	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	04/15/2014

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, 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 32 year old female who sustained an industrial injury on 06/28/2009. Diagnoses include thoracic/lumbosacral neuritis/radiculitis, degenerative lumbar/lumbosacral intervertebral disc, degeneration of cervical intervertebral disc and brachial neuritis or radiculitis. Treatment to date has included diagnostic studies, medications, and epidural steroid injections. A physician progress note dated 04/02/2014 documents the injured worker continues to complain of neck and lower back pain with radiation to the left arm and left leg. She rates her pain on a scale of 0-10 as a 9/10 today, and an average of 7-8, and 6-7 at best. The injured worker is depressed and is having difficulty sleeping. She has an antalgic gait, and there is tenderness noted in the left lumbar paravertebral regions and in the left sacroiliac joint at the L5-S1 level. Range of motion is restricted. She has a positive Stork test, Compression test and Gaenslen's test on the right. Cervical range of motion is restricted. Spurling's test is positive on the right for neck pain only, Spurling test is positive on the left for neck pain as well as radiculopathy. The treatment plan is for medications, and TENS replacement. Treatment requested is for One TENS Unit with electrodes and batteries supply, and Valium 10mg, #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Valium 10mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: In regard to the request for Valium (diazepam), Chronic Pain Medical Treatment Guidelines state the benzodiazepines are Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. The guidelines further states the following regarding benzodiazepines in the context as an anti-spasm agent: Benzodiazepines: Not recommended due to rapid development of tolerance and dependence. There appears to be little benefit for the use of this class of drugs over non-benzodiazepines for the treatment of spasm. In the submitted medical records available for review, the patient has ongoing use of Valium since 10/2012, and there is no documentation identifying any objective functional improvement as a result of the use of the medication. The CA MTUS recommendation against long-term use. Benzodiazepines should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In the absence of such documentation, the currently requested Valium 10mg #30 is not medically necessary.

One TENS Unit with electrodes and batteries supply: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation). Decision based on Non-MTUS Citation Neuropathic pain: Some evidence (Chong, 2003), including diabetic neuropathy (Spruce. 2002) and post-herpetic neuralgia. (NIV, 2005).

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

Decision rationale: Regarding the request for the replacement TENS with electrodes and battery supply, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is 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. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach, with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Within the documentation available for review, there is indication that the patient has undergone a TENS unit trial with documentation of improvement in functional deficits. However, it is unclear what other treatment modalities are currently being used within a functional restoration approach. In the absence of clarity regarding this issue, the currently requested TENS unit with electrodes and battery supply are not medically necessary.