

<b>Case Number:</b>	CM15-0062268		
<b>Date Assigned:</b>	04/08/2015	<b>Date of Injury:</b>	10/11/2000
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	03/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/01/2015

### 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 60 year old male, who sustained an industrial injury on 10/11/00. The mechanism of injury was not provided. The injured worker was diagnosed as having thoracolumbar spine sprain with left sacroiliac sprain and left leg radiculitis and L4-5 left sided disc protrusion with stenosis and multilevel bilateral facet hypertrophy. Treatment to date has included transforaminal epidural steroid injection, home exercise program TENS unit and oral medications. The documentation of 3/02/2015 revealed the injured worker had complaints of low back pain radiating to the left leg with numbness and tingling to the foot and recent increase in symptoms in past 3 weeks. Physical exam revealed tenderness to palpation with moderate muscle spasm over the paravertebral musculature, left sacroiliac joint and left sciatic notch region and diminished range of motion of lumbar spine. The treatment plan included a request for authorization for weight watchers, chiropractic treatment, TENS unit, follow up appointment and medications including Ultram, Fexmid and Sonata.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultram 50mg, every 6 hours as needed, QTY: 120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 93-94, 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement, objective decrease in pain and documentation the injured worker was being monitored for aberrant drug behavior and side effects. Given the above, the request for Ultram 50 mg every 6 hours as needed, QTY: 120 is not medically necessary.

**Fexmid 7.5mg twice daily, #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** The California MTUS guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain, less than 3 weeks and there should be documentation of objective functional improvement. The clinical documentation submitted for review indicated this medication was a current medication. There was a lack of documentation of objective functional benefit. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations for less than 1 month use. Given the above, the request for Fexmid 7.5 mg twice daily #60 is not medically necessary.

**Sonata 10mg at bedtime, QTY: 30: 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), Insomnia treatment.

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

**Decision rationale:** The Official Disability Guidelines indicate that non-benzodiazepine sedative hypnotics are recommended as first line medications for insomnia. The clinical documentation submitted for review failed to indicate the injured worker had complaints of insomnia. There was a lack of documented efficacy for the requested medication. Given the above, the request for Sonata 10 mg at bedtime, QTY: 30 is not medically necessary.

**Chiropractic treatment to the low back, QTY: 8: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58, 59.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement a total of up to 18 visits over 6-8 weeks may be appropriate. The clinical documentation submitted for review indicated the injured worker had a musculoskeletal condition that would be appropriate for treatment. This request would be supported for 6 sessions. However, 8 sessions would be excessive. Given the above, the request for chiropractic treatment to the low back, QTY: 8 is not medically necessary.

**██████████ (in weeks), QTY: 10: 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), Lifestyle (diet & exercise).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Diabetes, Lifestyle (diet & exercise) modifications.

**Decision rationale:** The Official Disability Guidelines indicate that lifestyle diet and exercise modifications are recommended as first line interventions. The clinical documentation submitted for review failed to provide documentation the injured worker was participating in physical exercise and calorie counting. There was a lack of documentation of a failure of diet and exercise modifications. Given the above, the request for ██████████ (in weeks), QTY: 10 is not medically necessary.

**Back garment for low back/TENS supplies: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines TENS unit Page(s): 114-116.

**Decision rationale:** The American College of Occupational and Environmental Medicine guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Additionally, continued use of back braces could lead to

deconditioning of the spinal muscles. The clinical documentation submitted for review failed to provide documentation of exceptional factors. There was a lack of documentation indicating the injured worker had a reinjury. As such, the request for a back garment for low back is not medically necessary. The California Medical Treatment Utilization Schedule guideline indicate that a one month trial of a TENS unit is recommended if it is used as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. There was a lack of documentation indicating the objective functional benefit that was received from the prior TENS unit usage. There was a lack of documentation of a decrease in pain with the use of the unit. The request as submitted failed to indicate the specific TENS supplies that were being requested. Given the above, the request for back garment for low back/TENS supplies is not medically necessary.