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| Case Number: | CM15-0090695 | | |
| Date Assigned: | 05/15/2015 | Date of Injury: | 08/13/2008 |
| Decision Date: | 07/01/2015 | UR Denial Date: | 04/29/2015 |
| Priority: | Standard | Application Received: | 05/11/2015 |

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:

This 37 year old woman sustained an industrial injury on 8/13/2008. The mechanism of injury is not detailed. Diagnoses include discogenic lumbar condition with herniation. Treatment has included oral medications. Physician notes dated 4/3/2015 show complaints of right side sciatica. Recommendations include activity modification, replace TENS pads, physical therapy, Tylenol #3, Protonix, Naproxen, Flexeril, and follow up in four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS (trancutaneous electrical nerve stimulation) Pads, unspecified qty: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (trancutaneous electrical nerve stimulation) Page(s): 114-115.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 116.

Decision rationale: Based on the 4/3/15 progress report provided by the treating physician, this patient presents with mid-back pain, low back pain, and sciatica on the right side with occasional

muscle spasm/stiffness. The treater has asked for TENS PADS, UNSPECIFIED QTY on 4/3/15. The 2/27/15 report states: "she needs replacement of TENS pad which she has been using more regularly lately as her previous pad has worn out." The patient's diagnosis per request for authorization form dated 4/3/15 is oth and unspec disc D/O lumbar region. The patient is s/p TENS unit, lumbar support, hot/cold wrap, and chiropractic therapy. The patient has an MRI from 9/20/14 showing disc protrusion at L4-5 and nerve studies have been unremarkable per 1/16/15 report. The patient is currently not working, as she is attending school per 4/3/15 report. For TENS unit, MTUS guidelines, on page 116, require (1) Documentation of pain of at least three months duration (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed. (3) A one-month trial period of the TENS unit 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; rental would be preferred over purchase during this trial. (4) Other ongoing pain treatment should also be documented during the trial period including medication usage (5) A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted (6) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. Criteria for Use of TENS Unit on page 116 and state that "There is evidence that other appropriate pain modalities have been tried (including medication) and failed." In addition, the recommended trial period is for only 30 days. The requested TENS pad replacement appears reasonable. The patient presents with radicular pain, a neuropathic condition for which MTUS supports the use of TENS. The treater indicates that the patient has been using it regularly with some benefit. The patient would need regular refills of the pads to continue to be able to use the TENS. The request IS medically necessary.

Physical Therapy, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: Based on the 4/3/15 progress report provided by the treating physician, this patient presents with mid-back pain, low back pain, and sciatica on the right side with occasional muscle spasm/stiffness. The treater has asked for PHYSICAL THERAPY 12 SESSIONS on 4/3/15 "to improve range of motion, function, and strength." The patient's diagnosis per request for authorization form dated 4/3/15 is oth and unspec disc D/O lumbar region. The patient is s/p TENS unit, lumbar support, hot/cold wrap, and chiropractic therapy. The patient has an MRI from 9/20/14 showing disc protrusion at L4-5 and nerve studies have been unremarkable per 1/16/15 report. The patient is currently not working, as she is attending school per 4/3/15 report. MTUS pages 98 and 99 have the following: "Physical medicine: Recommended as an indicated below. Allow for fading of treatments frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS Guidelines pages 98 and 99 state that for myalgia, myositis, 9 to 10 visits are recommended over 8 weeks, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits are recommended. Review of the reports dated 12/12/14 to 4/3/15 do not

show any evidence of recent physical therapy being done. However, treater has not provided a precise treatment history, nor documented efficacy of prior therapy. Furthermore, the request for 12 sessions exceeds what is allowed by MTUS for the patient's condition. Therefore, the request IS NOT medically necessary.

Tylenol #3, Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80, 86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use of opioids, medication for chronic pain Page(s): 88-89-, 76-78,60-61.

Decision rationale: Based on the 4/3/15 progress report provided by the treating physician, this patient presents with mid-back pain, low back pain, and sciatica on the right side with occasional muscle spasm/stiffness. The treater has asked for TYLENOL #3 QTY 60 on 4/3/15. The patient's diagnosis per request for authorization form dated 4/3/15 is oth and unspec disc D/O lumbar region. The patient is s/p TENS unit, lumbar support, hot/cold wrap, and chiropractic therapy. The patient has an MRI from 9/20/14 showing disc protrusion at L4-5 and nerve studies have been unremarkable per 1/16/15 report. The patient is currently not working, as she is attending school per 4/3/15 report. 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 4As (analgesia, ADLs, adverse side effects, and adverse 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. Regarding medications for chronic pain MTUS Guidelines pg. 60, 61 states: "Before prescribing any medication for pain the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded." Tylenol No. 3 has not been prescribed for the patient per review of reports, but the patient was taking Tramadol per 12/12/14, 1/16/15 and 2/27/15 reports. The patient states Tramadol makes her sick, and cannot tolerate Vicodin or Norco per 4/23/15 report. In regard to the prescription of Tylenol No. 3, the request is appropriate. This is the initiating prescription of this medication, as the provider notes that the patient is unable to tolerate Tramadol. Given this patient's ongoing chronic pain condition, a trial of Tylenol No. 3 is substantiated. Therefore, the request IS medically necessary.

Flexeril 7.5 mg Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: Based on the 4/3/15 progress report provided by the treating physician, this patient presents with mid-back pain, low back pain, and sciatica on the right side with occasional muscle spasm/stiffness. The treater has asked for FLEXERIL 7.5MG QTY 60 on 4/3/15. The patient's diagnosis per request for authorization form dated 4/3/15 is oth and unspec disc D/O lumbar region. The patient is s/p TENS unit, lumbar support, hot/cold wrap, and chiropractic therapy. The patient has an MRI from 9/20/14 showing disc protrusion at L4-5 and nerve studies have been unremarkable per 1/16/15 report. The patient is currently not working, as she is attending school per 4/3/15 report. MTUS Chronic Pain Medical Treatment Guidelines, page 63-66 states: "Muscle relaxants: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions." In regard to the request for Flexeril, the provider has specified an excessive duration of therapy. This patient has been prescribed Cyclobenzaprine since at least 12/12/14. Guidelines indicate that muscle relaxants such as Cyclobenzaprine are considered appropriate for acute exacerbations of lower back pain. However, MTUS Guidelines do not recommend use of Cyclobenzaprine for longer than 2 to 3 weeks, the requested 60 tablets does not imply short duration therapy. Therefore, the request IS NOT medically necessary.