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| Case Number: | CM15-0091746 | | |
| Date Assigned: | 05/18/2015 | Date of Injury: | 06/24/2003 |
| Decision Date: | 06/17/2015 | UR Denial Date: | 05/06/2015 |
| Priority: | Standard | Application Received: | 05/12/2015 |

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: Emergency Medicine

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 39 year old male, who sustained an industrial injury on 6/24/2003. The medical records submitted for this review did not include the details regarding the initial injury. Diagnoses include myalgia and myositis, spinal stenosis and radiculopathy. Treatments to date include medication therapy, lumbar epidural steroid injections, and H Wave therapy in home use. Currently, he complained of low back pain with right lower extremity pain. Pain was rated 8/10 VAS with medication and 10/10 VAS without medications. On 4/27/15, the physical examination documented the gait was antalgic with difficulty and pain upon transferring sitting to standing. There was lumbar tenderness without muscle spasm. The treating diagnoses included myalgia and myositis, lumbar spinal stenosis, and radiculopathy. The plan of care included Morphine extended release capsule 30mg, one capsule twice a day quantity #60 for thirty day supply; oxycodone-acetaminophen 12/325mg tablets, one tablet four times a day #120 for a thirty day supply. The request was to approve these medications once a month for the months until next follow up visit scheduled for 7/20/15. There was also a request to authorize H Wave electrode supplies for one year.

IMR ISSUES, DECISIONS AND RATIONALES

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

Morphine Extended Release #60 (Dispense 90 Day Supply): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82 Page(s): 78-82.

Decision rationale: The requested Morphine Extended Release #60 (Dispense 90 Day Supply), is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has low back pain with right lower extremity pain. Pain was rated 8/10 VAS with medication and 10/10 VAS without medications. On 4/27/15, the physical examination documented the gait was antalgic with difficulty and pain upon transferring sitting to standing. There was lumbar tenderness without muscle spasm. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Morphine Extended Release #60 (Dispense 90 Day Supply) is not medically necessary.

Oxycodone 10/325 #120 (Dispense 90 Day Supply): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82 Page(s): 78-82.

Decision rationale: The requested Oxycodone 10/325 #120 (Dispense 90 Day Supply) , is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has low back pain with right lower extremity pain. Pain was rated 8/10 VAS with medication and 10/10 VAS without medications. On 4/27/15, the physical examination documented the gait was antalgic with difficulty and pain upon transferring sitting to standing. There was lumbar tenderness without muscle spasm. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Oxycodone 10/325 #120 (Dispense 90 Day Supply) is not medically necessary.

Request H-Wave Electrodes for 1 Year: 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT) Page(s): 117-118.

Decision rationale: The requested Request H-Wave Electrodes for 1 Year, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Pages 117-118, H-Wave Stimulation (HWT), noted that H-wave is "Not recommended as an isolated intervention, but a one-month home-based trial of H-Wave stimulation may be considered as a noninvasive conservative option for diabetic neuropathic pain, or chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). The injured worker has low back pain with right lower extremity pain. Pain was rated 8/10 VAS with medication and 10/10 VAS without medications. On 4/27/15, the physical examination documented the gait was antalgic with difficulty and pain upon transferring sitting to standing. There was lumbar tenderness without muscle spasm. The treating physician has not documented detailed information regarding TENS trials or their results, nor objective evidence of functional improvement from H-wave usage. The criteria noted above not having been met, Request H-Wave Electrodes for 1 Year is not medically necessary.