

Case Number:	CM15-0099247		
Date Assigned:	06/01/2015	Date of Injury:	01/12/2004
Decision Date:	07/07/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	05/22/2015

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: New Jersey, New York
 Certification(s)/Specialty: Family Practice

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 58 year old female who reported an industrial injury on 1/12/2004. Her diagnoses, and/or impressions, are noted to include: chronic pain syndrome with neck and left upper extremity pain; cervical myofascial pain syndrome and spondylosis; chronic low back and right lower extremity pain with thoracolumbar myofascial pain syndrome and thoracic/lumbar spondylosis; lumbar radiculopathy and discopathy with disc displacement and status-post lumbar fusion; bilateral sacroiliac arthropathy; right knee internal derangement; and reactive depression and anxiety. No current imaging studies are noted. Her treatments have included multiple diagnostic studies; physical therapy; an agreed panel medical evaluation on 9/29/2010; use of a rolling walker; long-term medication management with urine toxicology screenings; and permanent work restrictions. The progress notes of 4/20/2015 reported complaints of constant, severe low back pain, right > left, that radiated down the right leg/knee, associated with numbness/tingling; and multiple falls. The objective findings were noted to include diffusely diminished sensation, and hypo-reflexive/symmetric, in the right lower limb; use of a rolling walker in a step-to gait; decreased strength in the right hip and bilateral knees; decreased extensor hallucis longus, right > left; decreased range-of-motion; positive right straight leg raise, compression test and FABER's test on the right; and the inability to complete special testing. The physician stated that there was no evidence of chronic pain syndrome but there was evidence of myofascial pain syndrome. The physician's requests for treatments were noted to include consideration for a functional restoration program evaluation; a transcutaneous electrical nerve

stimulation unit; short-term use of Diclofenac ER for inflammation, with close blood pressure monitoring; and continuation of Omeprazole, and Trazadone

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Functional restoration program evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs Page(s): 49.

Decision rationale: The request is considered not medically necessary. An FRP would be indicated in a patient who has failed conservative treatment and is without any other options that would improve his symptoms. The patient has not been documented to have failed all modalities of conservative treatment. There was no documentation of baseline functional testing, motivation of the patient to change, or that negative predictors of success have been addressed. Until then, the request is considered not medically necessary.

60 day TENS unit trial: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-115.

Decision rationale: The request is not medically necessary. A trial of TENS unit is reasonable as an adjunct to a functional restoration program when other conservative appropriate pain modalities have failed. The patient is not documented to have failed all conservative therapy. She is also not certified for a functional restoration program. As per MTUS guidelines, TENS "does not appear to have an impact on perceived disability or long-term pain" in the management of chronic low back pain. Therefore, the request is considered not medically necessary.

Diclofenac ER 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Diclofenac (Voltaren).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDS, diclofenac.

Decision rationale: The MTUS does not address this drug, but the ODG states that this drug is not "recommended as first line due to increased risk profile." Diclofenac has been found to increase cardiovascular risk. The patient has a cardiac history with hypertension and an EKG showing a possible anterior infarct. Diclofenac would not be the first-line NSAID for this patient. Therefore, the request is considered not medically necessary.

Omeprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, PPI, NSAIDs, GI risk.

Decision rationale: The request for Omeprazole is not medically necessary. There is no documentation of GI risk factors or history of GI disease requiring PPI prophylaxis. The use of prophylactic PPI's is not required unless she is on chronic NSAIDs. The patient's Diclofenac will not be certified. There was no documentation of GI symptoms that would require a PPI. Long term PPI use carries many risks and should be avoided. Therefore, this request is medically unnecessary.

Trazodone 50mg #30 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trazodone. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress, Trazodone.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental/stress, Trazodone.

Decision rationale: The request is considered not medically necessary. According to ODG guidelines, Trazodone is recommended for insomnia when there is a potentially coexisting mild psychiatric symptoms. The patient was noted to have a depression. However, the patient's insomnia was due to Pamelor which was discontinued. The patient was documented to be sleeping 8 hours a night with episodes of nocturia. Therefore, Trazodone is considered not medically necessary.