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| Case Number: | CM14-0114676 | | |
| Date Assigned: | 09/18/2014 | Date of Injury: | 12/11/2000 |
| Decision Date: | 08/18/2015 | UR Denial Date: | 07/15/2014 |
| Priority: | Standard | Application Received: | 07/21/2014 |

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: New York, Pennsylvania, Washington
 Certification(s)/Specialty: Internal Medicine, Geriatric 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 47 year-old male, who sustained an industrial injury on December 11, 2000. He reported a pop in his low back with radiation into the right leg. Treatment to date has included MRI of the lumbar spine, lumbar laminectomy, dural leak repair, bilateral lumbar medial branch blocks, external bone growth stimulator, epidural steroid injections, medications, and TENS unit. An evaluation on July 3, 2014 revealed the injured worker complained of back pain with radiation of pain into the bilateral lower extremities. He rated the pain a 7 on a 10 point scale with medications and a 10 on a 10-point scale with medications. He reported that his quality of life had worsened since the previous visit and his activity level had decreased. He reports that his medications are working well and that a caudal epidural steroid injection the previous month was effective for three days. On physical examination the injured worker had restricted range of motion of the lumbar spine. The range of motion was limited by pain. The injured worker exhibited spasms of the bilateral paravertebral muscles and was unable to heel walk and toe walk. Straight leg raise test was positive bilaterally and he had tenderness to palpation over the posterior iliac spine bilaterally. The diagnoses associated with the request included lumbar radiculopathy, post lumbar laminectomy syndrome, spasm of muscle, lumbar spine degenerative disc disease, and low back pain. The treatment plan included psych consultation for evaluation for intrathecal pump, inversion table, polar ice machine, acupuncture therapy, TENS unit, Soma, Dilaudid and Methadone.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Polar ice machine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-310.

Decision rationale: This worker has chronic pain with an injury sustained in 2000. In this case, there is no documentation of inflammation and/or why the polar ice machine is needed for the current state. Also, it is not clear why the application of ice packs cannot be used instead of a ice machine. The medical necessity for a polar ice machine is not substantiated in the records. Therefore, the request is not medically necessary.

12 Acupuncture visits: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 4, 8-9.

Decision rationale: Acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Time to produce functional improvement is 3 to 6 treatments. The records do not indicate that the worker is not able to return to productive activities or that the worker is participating in an ongoing exercise program to which the acupuncture would be an adjunct. Additionally, in this injured worker, the medical records do not show that pain medication was reduced or not tolerated to support the medical necessity for acupuncture treatments. Therefore, the request is not medically necessary.

Dilaudid 4mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 74-80.

Decision rationale: Per the guidelines, in opioid use, on-going review and documentation of pain relief, functional status, appropriate medication use and side effects is required. Satisfactory response to treatment may be reflected in decreased pain, increased level of function or improved

quality of life. The MD visit fails to document any significant improvement in pain, functional status or a discussion of side effects specifically related to dilaudid to justify use per the guidelines. Additionally, the long-term efficacy of opioids for chronic back pain is unclear but appears limited. The medical necessity of dilaudid is not substantiated in the records. Therefore, the request is not medically necessary.

Methadone 10mg #270: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 74-80.

Decision rationale: Per the guidelines, in opioid use, ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects is required. Satisfactory response to treatment may be reflected in decreased pain, increased level of function or improved quality of life. The MD visit fails to document any significant improvement in pain, functional status or a discussion of side effects specifically related to methadone to justify use per the guidelines. Additionally, the long-term efficacy of opioids for chronic back pain is unclear but appears limited. The medical necessity of methadone is not substantiated in the records. Therefore, the request is not medically necessary.