

<b>Case Number:</b>	CM13-0020250		
<b>Date Assigned:</b>	06/06/2014	<b>Date of Injury:</b>	07/19/2004
<b>Decision Date:</b>	07/14/2014	<b>UR Denial Date:</b>	08/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/05/2013

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Mississippi. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 employee is a 39-year-old male who sustained a work-related injury on July 19, 2004. The specific mechanism of injury is not stated. The injured employee was seen on July 2, 2014, and the notes on this date states that the injured employee fell down and was seen at the emergency department complaining of left sided low back pain. The physical examination noted tenderness at the left lower thoracic region near T10-T12 and decreased range of motion of the thoracic spine secondary to pain. There was a diagnosis of lumbar radiculitis, cervical degenerative disc disease and failed back syndrome. Medications were refilled, and acupuncture as well as a TENS unit were recommended. There was a follow up appointment on July 30, 2013, and the injured employee complained of left sided low back pain and mid back pain. Severe tenderness and spasm are more noted at the left lower thoracic region. Trigger point injections were administered, and medications were refilled, and there was a request for a short course of physical therapy, and a TENS unit for home use. A utilization management review, dated August 27, 2013, did not recommend a request for Roxicodone, Thermacare patches, use of a TENS unit, or additional physical therapy. A request for Norco and Ambien were recommended, and a request for Xanax was modified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ROXICODONE 30 MG #180: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Opioids for Chronic Pain Page(s): 80.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state Roxicodone is an opioid only recommended for short-term pain relief for low back pain. Continued long-term usage of this medication should be justified with evidence of pain reduction, return to work and increased ability to perform activities of daily living. None of this information is supplied in the attached medical record. Without this information, chronic usage of Roxicodone is not recommended. Therefore, this request for Roxicodone is not medically necessary.

**XANAX 2 MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009), Barbiturate Containing Analgesic Agents Page(s): 23.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, Xanax is not intended for long-term use and carries a significant risk of dependency and tolerance. There is no justification in the attached medical record addressing the need for Xanax nor any mention for what it is intended to treat. Without this information supplied, this request for Xanax is not medically necessary.

**THERMACARE HEAT PATCHES #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Heat therapy, updated June 10, 2014.

**Decision rationale:** It is unclear from this request whether Thermacare patches were requested for the knee or for the back. Official Disability Guidelines (ODG) state that Thermacare patches are not recommended for the knee and only for the back for acute back pain. As the injured employee is into the chronic stage of low back pain, this request for Thermacare patches is not medically necessary.

**(1) TENS UNIT:** 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:** Although the use of a TENS unit is recommended for home use after a successful one month trial this unit is only recommended for neuropathic pain and chronic regional pain syndrome according to Chronic Pain Medical Treatment Guidelines. The injured employee has not been diagnosed with either of these conditions. As the TENS unit is not indicated for use for this employees condition this request for a TENS unit is not medically necessary.