

<b>Case Number:</b>	CM13-0055944		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	12/31/2009
<b>Decision Date:</b>	03/28/2014	<b>UR Denial Date:</b>	11/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 physician 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 patient is a 61-year-old injured worker who reported an injury on 12/31/2009. The mechanism of injury involved heavy lifting. The patient is diagnosed with lumbar spine myofasciitis, medication induced gastritis, and sleep disturbance. The patient was seen by ■■■. ■■■ on 11/07/2013. The patient reported severe flare up of low back pain. Physical examination revealed tenderness to palpation, 2+ spasm, limited range of motion, and positive sciatic tension to bilateral lower extremities. Treatment recommendations included a short course of physical therapy, a TENS unit, lumbar spine support, and continuation of current medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 lumbar brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

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

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The

patient's physical examination does not reveal significant instability. The medical necessity for the requested durable medical equipment has not been established. The request for 1 lumbar brace is not medically necessary and appropriate.

**1 TENS unit, set of batteries, and electrodes for VQ Ortho Care unit: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment as a primary treatment modality, but a 1 month home-based trial may be considered as a non-invasive conservative option. The patient currently utilizes an ortho stimulator. Despite ongoing treatment, the patient continues to report severe pain. There is no evidence of a satisfactory 1 month trial period of a TENS unit. There is also no indication that other appropriate pain modalities have been tried and failed. The request for 1 TENS unit, set of batteries, and electrodes for VQ Ortho Care unit is not medically necessary and appropriate.

**Eight physical therapy sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. As per the documentation submitted, the patient has completed a prior physical therapy course, and has been instructed in a home exercise program. Although it is noted that the patient has indicated a recent increase in symptoms, guidelines recommend an assessment after a 6 visit clinical trial. Therefore, the current request for 8 sessions of physical therapy is an excess of guideline recommendations. Additionally, there was no documentation of the patient's previous course of physical therapy with total treatment duration and efficacy. The request for eight physical therapy sessions is not medically necessary and appropriate.

**Norco: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report severe pain. Satisfactory response to treatment has not been indicated. The request for Norco is not medically necessary and appropriate.

**Protonix:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal complaints. The request for Protonix is not medically necessary and appropriate.