MAXIMUS Federal Services

| Case Number: | CM14-0005802 | | |
|---|---|---|---|
| Date Assigned: | 02/07/2014 | Date of Injury: | 07/11/2003 |
| Decision Date: | 08/07/2014 | UR Denial Date: | 01/06/2014 |
| Priority: | Standard | Application Received: | 01/15/2014 |

## 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management, and is licensed to practice in New York and TExas. 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 worker is a 56-year-old injured on July 11, 2003 due to an undisclosed mechanism of injury. Current diagnoses include status post anterior cervical discectomy and fusion at C5-6 and C6-7, hypermobility with junctional pathology and disc annular tear at C4-5, bilateral carpal tunnel syndrome, and depressive disorder. The clinical note dated November 20, 2013 indicates the injured worker presented complaining of stabbing pain in the neck, left shoulder, and hand with associated numbness and tingling. The documentation indicates the injured worker requires chronic management of long term pain with Norco, Ambien, and Ativan which helped to reduce symptoms. Physical examination revealed positive compression sign, painful range of motion of the left upper extremity with tenderness to palpation. The injured worker received intramuscular injections consisting of 60mg of Toradol and Vitamin B12 complex. The plan of care includes prescription for Flexeril 10mg twice daily as needed with 3 refills for spasms, Hydrocodone/ Acetaminophen 10/325mg every 6 hours with 3 refills for pain relief, Ativan 1mg PO QD with 3 refills for anxiety, and Ambien 10mg every evening with 3 refills for sleep. The documentation indicates the use of a transcutaneous electrical nerve stimulation (TENS) unit; however, efficacy is not addressed. The initial request for Flexeril 10mg #60 with 3 refills and TENS unit supplies was initially non-certified on Janaury 6, 2014.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexeril 10mg, sixty count with three refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Cyclobenzaprine Page(s): 41.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, cyclobenzaprine is recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the injured worker has exceeded the two to four week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. Additionally, the physical examination failed to provide objective findings significant for spasm necessitating the use of muscle relaxants. The request for Flexeril 10mg, sixty count, is not medically necessary or appropriate.

**TENS (transcutaneous electrical nerve stimulation) unit supplies:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 116.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, TENS use is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. Criteria for TENS use includes documentation of pain of at least three months duration; evidence that other appropriate pain modalities have been tried (including medication) and failed; a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial; other ongoing pain treatment should also be documented during the trial period including medication usage; and a treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. The clinical note failed to provided appropriate documentation to establish the length of time the TENS unit has been in use, any benefit achieved as evidenced by pain relief, functional improvement, and decrease in medication use. The request for TENS unit supplies is not medically necessary or appropriate.