

<b>Case Number:</b>	CM14-0101598		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	09/19/2007
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	06/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/01/2014

### 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 Occupational Medicine 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 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:

This injured worker is a woman with a date of injury on April 17, 2006. She complains of 5-7/10 upper and lower back pain aggravated with sitting, standing, and prolonged walking. She has obtained pain relief with a back corset, medication, massage, and heat. Exam is noted for tenderness in the bilateral trapezius, bilateral thoracic spine area, bilateral lumbar paraspinal and sacroiliac area; anywhere the physician presses is noted to "hurt." Medications include Neurontin, Ultram, Voltaren gel, omeprazole and Cymbalta. Her diagnoses include chronic pain syndrome, greater trochanteric bursitis, myofascial pain syndrome, low back pain, neck pain, limb pain. Her magnetic resonance imaging findings include degenerative disc disease at C5-6, Tarlov cysts at T9 and T10, and facet hypertrophy and mild disc bulge of L5-S1 with mild impingement of the left S1 nerve root. A visit to her physician on July 24, 2014 is noted to have resulted in a prescription for a transcutaneous electrical nerve stimulation unit at the worker's insistence.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit and all accessories:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114.

**Decision rationale:** Per the Medical Treatment Utilization Schedule guidelines, a one-month home-based transcutaneous electrical nerve stimulation unit trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. While a transcutaneous electrical nerve stimulation unit may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Several published evidence-based assessments of transcutaneous electrical nerve stimulation have found that evidence is lacking concerning effectiveness. The criteria for the use of transcutaneous electrical nerve stimulation include: - There is evidence that other appropriate pain modalities have been tried (including medication) and failed - A one-month trial period of the transcutaneous electrical nerve stimulation 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 - A treatment plan including the specific short- and long-term goals of treatment with the transcutaneous electrical nerve stimulation unit should be submitted. None of these conditions have been fulfilled with this individual. She has pain relief with medications, a one-month trial has not been fulfilled, and there is no treatment plan. Additionally, it is noted that the unit was ordered only at the worker's insistence, not at the judgment of the physician. Therefore, a transcutaneous electrical nerve stimulation/ electrical muscle stimulation unit purchase/rental is not medically necessary/appropriate.

**Lidoderm patches 5% #100:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57.

**Decision rationale:** Per the Medical Treatment Utilization Schedule guideline, topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic, serotonin-norepinephrine reuptake inhibitors, or anti-epileptic drugs such as gabapentin). This is not a first-line treatment and is only Food and Drug Administration-approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. There is no documentation that this worker has failed a first-line medication therapy, as she is still taking gabapentin. Therefore, this service is not considered medically necessary.

**Voltaren Gel 1% 2gm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs,Topical Analgesics Page(s): 111-113.

**Decision rationale:** Topical nonsteroidal anti-inflammatory drugs may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Indication for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical nonsteroidal anti-inflammatory drugs for treatment of osteoarthritis of the spine, hip, or shoulder. They are not indicated for neuropathic pain, as there is no evidence to support use. Voltaren Gel 1% (Diclofenac) is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. The worker has not failed oral medications for pain control, as she is taking them, and she has been using Voltaren gel in the past several months for her chronic musculoskeletal pain. It is recommended for short-term use only per the Medical Treatment Utilization Schedule guideline, and is therefore not medically necessary.