

<b>Case Number:</b>	CM14-0033957		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	04/22/2000
<b>Decision Date:</b>	07/22/2014	<b>UR Denial Date:</b>	02/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/18/2014

### 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 Otolaryngologist and is licensed to practice in 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 67-year-old male with a reported injury on 04/22/2000. The mechanism of injury was not provided within the clinical notes. The clinical note dated 01/27/2014 reported that the injured worker complained of left leg and back pain. The physical examination revealed active trigger points to bilateral deep quadrant lumborum. The injured worker's diagnoses included back pain; sciatica; and myofascial pain. The injured worker's prescribed medication list included Trazodone, Percocet, Soma, and Pamelor. The provider requested supplies for interferential unit, the rationale was not provided; also for Fentanyl due to the inadequate pain relief from Percocet. The request for authorization was submitted on 03/18/2014. The injured worker's prior treatments included physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SUPPLIES FOR INTERFERENTIAL UNIT, SIX MONTHS INTERNAL BATTERY PER 1/29/14 RFA:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

**Decision rationale:** The request for supplies for interferential unit; six months internal battery, per 1/29/14 RFA is non-certified. The injured worker complained of left leg and back pain. The treating physician's rationale for the interferential unit was not provided within the clinical notes. The CA MTUS guidelines do not recommend the use of interferential current stimulation (ICS) as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. It is reported that the injured worker has decreased pain with transcutaneous electrical nerve stimulation (TENS) unit, the rationale for the interferential current stimulation unit was not provided. Within the provided documentation, an adequate and complete assessment of the injured worker's functional condition was not provided; there is a lack of documentation indicating the injured worker has significant functional deficits indicating the requirement of an interferential unit. Moreover, there is a lack of clinic information indicating that the injured worker has had a successful trial of an interferential unit. Furthermore, the requesting provider does not specify the utilization frequency or the location of application of the interferential unit being requested. As such, the request is not certified.

**FENTANYL 12UG, EVERY (Q) THREE (3) DAYS PER 1/27/14 REPORT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): Oral pharmaceutical section, Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system), Opioids, criteria for use, & Opioids, dosing Page(s): 44, 76, 86.

**Decision rationale:** The request for Fentanyl 12ug q three (3) days per 1/27/14 report is non-certified. The injured worker complained of left leg and low back pain. The treating physician's rationale for the Fentanyl is due to the inadequate pain relief from Percocet. The CA MTUS guidelines do not recommend duragesic (fentanyl transdermal system) as a first-line therapy. The MTUS guidelines recognize four domains that have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. The MTUS guidelines recommend that dosing not exceed 120mg oral morphine equivalents per day, and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. There is a lack of documentation noting that the injured worker has had urine drug screens to validate proper medication adherence in the submitted report. Furthermore, the requesting provider did not specify the quantity or the location of application for the medication being requested. Given the information, there is insufficient evidence to determine appropriateness to warrant medical necessity; therefore, the request is not certified.