

<b>Case Number:</b>	CM14-0034332		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	02/07/2010
<b>Decision Date:</b>	07/28/2014	<b>UR Denial Date:</b>	02/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2014

### 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 Neurological Surgery and is licensed to practice in California. 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 57-year-old male was reportedly injured on February 7, 2010. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated February 12, 2014, indicated that there were ongoing complaints of low back and left knee pain. Pain stated to be constant and increased by activities of daily living. Pain was decreased by use of medication, ice, and the use of a TENS unit. The physical examination demonstrated decreased lumbar spine range of motion. There was a decrease of lumbar spine failed back surgery syndrome, left knee pain status post meniscectomy, right knee pain status post surgery times 2, and bilateral SI joint dysfunction. Percocet, and gabapentin were prescribed. Robaxin was put on hold. There was a request for chiropractic therapy for the lumbar spine and replacement pads for a TENS unit. A request had been made for Percocet, gabapentin, chiropractic therapy for the lumbar spine, and replacement pads for a TENS unit and was not certified in the pre-authorization process on February 20, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines :8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 78.

**Decision rationale:** The most recent progress note, dated February 12, 2014, did not justify continued use of Percocet. There was no mention of specific objective pain relief related to this medication, increased ability to function, or increased ability to perform activities of daily living. There was also no mention of potential side effects or aberrant behavior. Therefore continued use of Percocet is not medically necessary.

**Gabapentin 300mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 16.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009 Page(s): 16.

**Decision rationale:** Gabapentin is an anti-epileptic medication indicated for neuropathic pain syndromes. The attached medical record does not contain specific documentation of neuropathic pain, nor is there documentation of an abnormal neurological examination on the most recent note dated February 12, 2014. Therefore, this request for gabapentin is not medically necessary.

**Chiropractic therapy 2X6 for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009 Page(s): 58.

**Decision rationale:** According to the attached medical record, there has been prior approval for 12 sessions of chiropractic therapy, but there has been no documentation of efficacy from these visits. Therefore, it is unclear why additional chiropractic therapy was recommended. This request for chiropractic therapy twice a week for six weeks for the lumbar spine is not medically necessary.

**Replacement pads for TENS unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain Page(s): 116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Page(s): 114-115.

**Decision rationale:** The use of a TENS unit is indicated for neuropathic pain syndromes. The attached medical record does not contain specific documentation of neuropathic pain, nor is there

documentation of an abnormal neurological examination on the most recent note dated February 12, 2014. Therefore, this request for continued use of a TENS unit and replacement pads is not medically necessary.