

<b>Case Number:</b>	CM14-0050395		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	01/10/2013
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	03/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2014

### 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 & Rehabilitation, and is licensed to practice in Texas and Ohio. 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 55-year-old male who reported an injury on 01/10/2013. The mechanism of injury was not specifically stated. Current diagnoses include Concussion, Musculoligamentous Sprain of the Cervical Spine, Musculoligamentous Sprain of the Lumbar Spine and Lumbar Disc Protrusion. The injured worker was evaluated on 05/29/2014 with complaints of constant pain in the cervical and lumbar spine rated 9/10. Physical examination revealed tenderness to palpation over the lumbar spine, restricted lumbar range of motion, positive straight leg raise, and decreased sensation. It is noted that the injured worker has been previously treated with Physical Therapy, Acupuncture, and two Lumbar Epidural Steroid Injections. The current medication regimen includes Motrin 800 mg, Zanaflex 4 mg, and Prilosec 20 mg. Treatment recommendations included a refill of the current medication regimen, a urine drug test, an x-force stimulator, an ice/heat unit, and a referral to a spine surgeon.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 X-Force Stimulator:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines May 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page 114-117 Page(s): 114-117.

**Decision rationale:** California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based trial may be considered as a noninvasive conservative option. There is evidence of an attempt at previous conservative treatment with Physical Therapy and Acupuncture. There is no documentation of a successful 1 month trial prior to the request for a unit purchase. Based on the clinical information received and the California MTUS Guidelines, the request is not medically necessary.

**Urine Drug Screen:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page 43, 77 and 89 Page(s): 43, 77, and 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

**Decision rationale:** California MTUS Guidelines state drug testing is recommended as an option using a urine drug screen to assess for the use or presence of illegal drugs. Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification. There is no evidence of noncompliance or misuse of medication. There is also no indication that this injured worker falls under a high-risk category that would require frequent monitoring. Therefore, medical necessity has not been established and the request is not medically necessary.

**Norco 10/325 #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines May 2009.

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

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur; the injured worker has been utilizing this medication since 12/2013. There is no documentation of objective functional improvement and there is no frequency listed in the current request. Therefore, the request is not medically necessary.

**1 Ice/Heat Unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 298-300.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state physical modalities have no proven efficacy in treating acute low back symptoms. In-home local applications of heat/cold are as effective as those performed by a therapist and there is no specific body part listed in the current request. There is also no mention of a contraindication to in-home local applications of heat/cold as opposed to a motorized unit. Medical necessity has not been established; therefore the request is not medically necessary.