

<b>Case Number:</b>	CM14-0053539		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	10/08/2012
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	04/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/22/2014

### 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 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 37 year old male injured on 10/08/12 while bending and lifting switch gear, weighing approximately 100 lbs., resulting in back and knee injuries. The clinical note dated 04/28/14 indicates the injured worker was complaining of lumbar spine pain radiating to the bilateral lower extremities with associated numbness and tingling into the feet. He rated the pain at 6/10. He complained of left knee pain but that it has improved to 4-5/10 from previous visit. He also reported popping and clicking sensations in the left knee, swelling, and giving way. In addition, the injured worker reported bilateral groin pain rated at 5/10 that can increase to 9/10 with certain movements. The pain was described as 'pressure-like'. Physical assessment revealed pain with palpation over the paravertebral muscles, left sacroiliac joint, left sciatic notch of the lumbar spine, pain with flexion/extension/left lateral bending in the lumbar spine, pain with bilateral leg raising, hypoesthesia noted at S1 dermatome on the left. The injured worker was advised to continue Norco as prescribed, discontinue back brace utilization, and continue other medications including Ibuprofen, Tramadol, and over the counter sleeping medication. The initial request for Vicodin 5/300mg #60 with one refill, one consultation with a general surgeon for the left inguinal hernia, one Transcutaneous Electrical Nerve Stimulation (TENS) unit, one consultation with a pain management specialist, and one X-force stimulation was initially non-certified on 04/16/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Vicodin 5/300mg #60 with 1 refill: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

**Decision rationale:** According to of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, Vicodin 5/300mg #60 with one refill is considered not medically necessary.

**One Consultation with a general surgeon for left inguinal hernia:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hernia Criteria for Hernia Repair (Inguinal, Umbilical, Diaphragmatic, Femoral, Ventral, or Incisional).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hernia, Office visits.

**Decision rationale:** According to prior documentation, the injured worker underwent hernia repair and is now complaining of bilateral groin pain that has failed to improve over several office visits. Based on the review of the records provided, prior surgical history and current subjective symptomology, evaluation by a general surgeon to establish the appropriate pathology is necessary. As such, the request for one consultation with a general surgeon for left inguinal hernia is considered medically necessary.

**One consultation with a pain management specialist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Disorder Medical Treatment Guidelines, State of Colorado Department of Labor and Employment, 4/27/2007, page 56.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chronic Pain, Introductory Material, General Principles of Treatment, page 127.

**Decision rationale:** According to the ACOEM, additional referrals are necessary when an injured worker's complaints of pain or dysfunction start to involve other body areas, there appear to be indications of significant psychosocial dysfunction or psychiatric comorbidity, specific

clinical findings suggest previously undetected clinical pathology requiring other expertise to adequately address it, or the clinical course does not follow generally expected patterns. The request for pain consultation is appropriate; however, should be deferred pending evaluation by general surgeon. As such, the request for one consultation with a pain management specialist is considered not medically necessary.

**One X-Force Stimulator:** 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, X force Stimulator use is not recommended as a primary treatment modality, but a one-month home-based X Force Stimulator trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. Criteria for X Force Stimulator use includes the following: 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 X Force Stimulator unit (as an adjunct to ongoing treatment modalities within a functional restoration approach) and documented 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 X Force Stimulator unit. The documentation lacked the required criteria. As such, the request for One X Force Stimulator is not medically necessary.

**One TENS Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic).

**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, Transcutaneous Electrical Nerve Stimulation (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 documentation lacked the required criteria. As such, the request for one TENS unit is not medically necessary.