

<b>Case Number:</b>	CM14-0093675		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	07/03/2008
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	06/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/20/2014

### 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 Emergency Medicine 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 68-year-old male who reported an injury on 07/03/2008. The mechanism of injury was not provided. On 05/07/2014, the injured worker presented with complaints of lower back pain. Upon examination, there was tenderness to palpation over the lumbar spine with pain with range of motion, and positive musculoskeletal spasm in the lumbar spine. The diagnoses were chronic sprain of the lumbar spine, degenerative disc disease of the lumbar spine, and a 4 mm disc protrusion at the L4-5 revealed on an MRI performed on 09/15/2008. The provider recommended a TENS unit to help decrease pain and spasms, a home exercise kit to increase range of motion and build muscle strength, conductive garments, Ultram, Soma, and Neurontin. The Request for Authorization Form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Stimulator with built-in TENS unit with 3 months' supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

**Decision rationale:** The request for an [REDACTED] stimulator with built-in TENS unit with 3 months supplies is not medically necessary. The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A 1-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. The results of studies are inconclusive, and 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. There is a lack of documentation indicating significant deficits on physical examination. The efficacy of the injured worker's previous courses of conservative care was not provided. It is unclear if the injured worker underwent an adequate TENS trial. It is also unclear if the injured worker needed to rent or purchase a TENS unit. The provider's request does not indicate the site at which the TENS unit is intended to be applied. As such, medical necessity has not been established.

**Two Conductive Garments:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary equipment request is not medically necessary, none of the associated supplies are medically necessary.

**[REDACTED] Home Exercise Kit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

**Decision rationale:** The request for an [REDACTED] home exercise kit is not medically necessary. The California MTUS guidelines state there is strong evidence that exercise programs including aerobic conditioning and strengthening are superior to treatment programs that do not include exercise. There is insufficient evidence to warrant a recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program unless exercise is contraindicated. As the guidelines state that there is no evidence to support the recommendation of any particular exercise regimen over other exercise regimens, an [REDACTED] home exercise kit would not be indicated. Additionally, there is a lack of information about what is included in the [REDACTED] home exercise kit. The request did not indicate whether the kit needed to be rented or purchased. As such, medical necessity has not been established.

**Ultram 50mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

**Decision rationale:** The request for Ultram 50mg #60 is not medically necessary. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There is a lack of evidence of an objective assessment of the injured worker's pain level and functional status, evaluation of risks for aberrant drug abuse behavior, and the presence or absence of side effects. The efficacy of prior use of the medication was not provided. Additionally, the provider's request did not indicate the frequency of the medication in the request as submitted. As such, medical necessity has not been established.

**Soma 350mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

**Decision rationale:** The request for Soma 350mg #60 is not medically necessary. The California MTUS guidelines do not recommend Soma. The medication is not indicated for long term use. Soma is a commonly-prescribed, centrally-acting skeletal muscle relaxant whose primary active metabolite is Meprobamate. Abuse has been noted for sedative and relaxing effects. As the guidelines do not recommend Soma, the medication would not be indicated. Additionally, the efficacy of prior use of the medication was not provided. The frequency of the medication was not provided in the request as submitted. As such, medical necessity has not been established.

**Neurontin 300mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drug.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-22.

**Decision rationale:** The request for Neurontin 300 mg #90 is not medically necessary. The California MTUS Guidelines state Neurontin has been shown to be effective for diabetic painful neuropathy and post-herpetic neuralgia and has been considered a first line treatment for neuropathic pain. After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The

continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. The efficacy of the medication is not documented. The provider's rationale was not provided. The provider's request does not indicate the frequency of the medication. As such, the request is non-certified. There is a lack of documentation of the efficacy of the prior use of the medication. The provider's request did not indicate the frequency of the medication in the request as submitted. As such, medical necessity has not been established.