

Case Number:	CM15-0018838		
Date Assigned:	02/06/2015	Date of Injury:	02/09/2006
Decision Date:	04/03/2015	UR Denial Date:	01/06/2015
Priority:	Standard	Application Received:	02/02/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 56-year-old male who reported an injury on 02/09/2006. The mechanism of injury was the injured worker was bending some bars with a hickey bar, which required him to forcefully bend, and as he did this, the hickey bar slipped and the injured worker fell downward a distance of approximately 12 to 16 feet. The injured worker underwent an open reduction internal fixation of a pelvis fracture on 12/16/2006. Prior therapies included physical therapy. The request for a TENS unit was made on 03/27/2014 originally. There was a Request for Authorization submitted for review from the date of 04/02/2014. The rationale was not provided. The rationale for the use of the TENS unit requested 03/27/2014 was to block pain. The original request for the back brace dated 07/22/2014. No rationale was provided. The prior therapies included cortisone injections. The documentation indicated the injured worker was utilizing NSAIDs, antidepressants, Protonix, and opiates since at least 03/2014. There was a Request for Authorization submitted for review for the back brace dated 07/23/2014. The documentation indicated that the injured worker had utilized muscle relaxants since at least 08/20/2014. The documentation of 11/13/2014 revealed the injured worker had left knee, left foot, and low back pain. The injured worker had utilized inserts. The injured worker had an MRI of the knee revealing medial and lateral meniscus tear and anterior cruciate ligament tear. The injured worker had standing x-rays, which revealed 2 mm articular surface left. The x-rays prior to coming to the physician's practice revealed a mild element of tricompartmental arthritis. The injured worker had loss of motion so that he could not bend his knee to 90 degrees. The injured worker had instability and locking. The injured worker had positive laxity. Prior

therapies included physical therapy for the knee. The injured worker was noted to be approved for Flexeril, Effexor, and Nalfon. Physical examination revealed the injured worker had tenderness along the knee and flexion of 90 degrees. The injured worker had weakness to resisted function and anterior drawer instability of 2+, and the McMurray's test was equivocal. The diagnoses included status post fall from scaffolding with unstable bilateral pelvis fracture and L5 transverse process fracture, torn anterior sacroiliac ligament on the left for which the injured worker was status post open reduction internal fixation of the right sacroiliac fracture and pubic symphysis, discogenic lumbar condition with MRI in 11/2009, internal derangement of the left knee, plantar fasciitis on the left as well as inflammation of the talonavicular joint and retro Achilles tendon. The injured worker was status post 2 injections with a physician. The treatment plan included a knee brace, Nalfon 400 mg, Flexeril 7.5 mg, and Effexor SR 75 mg, Neurontin 600 mg, and blood testing for liver and kidney function that have not been done in a while as well as a comprehensive metabolic panel, CBC, and UA due to medication use. There was no Request for Authorization submitted for review for the requested medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) lumbar support and back support insert: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 301.

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

Decision rationale: The American College of Occupational and Environmental Medicine Guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Additionally, continued use of back braces could lead to deconditioning of the spinal muscles. The clinical documentation submitted for review failed to provide documented rationale that the injured worker had instability. There was a lack of documented rationale for the requested lumbar support. Given the above, the request for One (1) lumbar support and back support insert is not medically necessary.

One (1) TENS unit (IF muscle stimulator) with conductive garment: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Conductive Garment, Interferential Current Stimulation Page(s): 114-116, 118.

Decision rationale: The California Medical Treatment Utilization Schedule recommends a 1 month trial of a TENS unit as an adjunct to a program of evidence based functional restoration for chronic neuropathic pain. Prior to the trial, there must be documentation of at least 3 months of pain and evidence that other appropriate pain modalities have been tried (including

medication) and have failed. They do not recommend neuromuscular electrical stimulation (NMES devices), as there is no evidence to support its use in chronic pain. They do not recommend interferential current stimulation (ICS) as an isolated intervention. A form fitting TENS device is only considered medically necessary when there is documentation that there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment, that the patient has medical conditions that prevents the use of the traditional system, or the TENS unit is to be used under a plastered splint (as in treatment for disuse atrophy). The clinical documentation submitted for review indicated the injured worker had pain. However, there was a lack of documentation that other appropriate pain modalities had been trialed, including medication, and had failed. There was a lack of documentation indicating the injured worker had such a large area that required stimulation that a conventional system could not accommodate the treatment. Additionally, the request as submitted failed to indicate whether the unit was for rental or purchase. There was a lack of documentation indicating the unit would be used as an adjunctive therapy. Given the above, the request for one (1) TENS unit (IF muscle stimulator) with conductive garment is not medically necessary.

One (1) referral for pain management for low back and possible epidural injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 1.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend upon ruling out a potentially serious condition, conservative management is provided. If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. The clinical documentation submitted for review failed to provide documentation the injured worker had objective findings upon physical examination and MRI findings that would support the necessity for an epidural steroid injection. Given the above, the request for one (1) referral for pain management for low back and possible epidural injection is not medically necessary.

One (1) prescription of Nalfon 400mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend NSAIDs for the short term symptomatic relief of pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documentation of objective

functional benefit and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for one (1) prescription of Nalfon 400mg #60 is not medically necessary.

One (1) prescription of Flexeril 7.5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for short term treatment of acute low back pain. Their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documentation of objective functional improvement, and there was lack of documentation of exceptional factors. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for one (1) prescription of Flexeril 7.5mg #60 is not medically necessary.

One (1) prescription of Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. The clinical documentation submitted for review failed to indicate the injured worker had documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for one (1) prescription of Tramadol ER 150mg #30 is not medically necessary.

One (1) prescription of Protonix 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that proton pump inhibitors are recommended for injured workers at intermediate or high risk for gastrointestinal events. Injured workers with no risk factors and no cardiovascular disease do not require the use of a proton pump inhibitor. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documented efficacy. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating the injured worker had been assessed and found to be at intermediate or high risk for gastrointestinal events. Given the above, the request for one (1) prescription of Protonix 20mg #60 is not medically necessary.

One (1) CBC, BMP: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 70.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that the package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. The clinical documentation submitted for review indicated the injured worker had not been tested recently. However, the prior laboratory studies were not provided for review. Given the above, the request for one (1) CBC, BMP is not medically necessary.

One (1) ten panel urine screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 70.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that the package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. The clinical documentation submitted for review indicated the injured worker had not been tested recently. However, the prior laboratory studies were not provided for review. The physician documentation indicated the injured worker needed to be tested due to medication use. The request as submitted failed to indicate the specific components of the 10 panel urine screen. Given the above, the request for one (1) ten panel urine screen is not medically necessary.