

<b>Case Number:</b>	CM15-0025707		
<b>Date Assigned:</b>	02/18/2015	<b>Date of Injury:</b>	09/11/2013
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	02/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2015

### 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: Florida  
 Certification(s)/Specialty: Family Practice

### 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 43 year old male, who sustained an industrial injury on 09/11/2013. He has reported low back pain. The diagnoses have included lumbar sprain/strain; lumbar stenosis; and lumbar radiculopathy. Treatment to date has included medications, physical therapy, home exercise program, and surgical intervention. Medications have included Relafen, Lunesta, and Ativan. Surgical intervention has included lumbar L4-5 microlaminectomy and discectomy, performed on 12/03/2013; and lumbar spine microlaminectomy and discectomy as a revision, performed on 10/01/2014. Currently, the injured worker complains of constant low back pain that radiates in the bilateral lower extremities; lumbar range of motion is reduced; intermittent left hip pain that radiates to the left knee and left ankle/foot/toes with numbness; and reports improvement with physical therapy. A progress note from the treating physician, dated 01/14/2015, reported objective findings to include tenderness to palpation over the L5-S1 bilaterally, in the left sciatic notch, in the left posterior thigh/calf; and limited range of motion. Request is being made for TENS (transcutaneous electrical nerve stimulation) unit; large ice pack pad; and Lunesta. On 02/02/2015 Utilization Review modified a prescription for TENS Unit Purchase, to TENS Unit one month trial to allow for functional improvement; noncertified a prescription for Large Ice Pack Pad; and modified a prescription for Lunesta Tab 3 mg, to potentially allow for weaning at 10 percent every four weeks to a quantity of 27, then to re-assess with AP for additional weaning. The CA MTUS and the ODG were cited. On 02/10/2015, the injured worker submitted an application for a prescription for TENS Unit Purchase; Large Ice Pack Pad; and Lunesta Tab 3 mg.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS Unit Purchase:** Upheld

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

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

**Decision rationale:** California MTUS guidelines recommend the following regarding criteria for TENS unit use: 1. Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. 2. There is 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. 3. Other ongoing pain treatment should also be documented during the trial period including medication usage. 4. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. 5. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. This patient's case does not meet the recommended MTUS criteria since no treatment plan (that includes short and long term goals) was submitted. There is also no documentation of a one month trial period with subsequent documentation of the functional benefits obtained. Likewise, this request for a TENS unit rental is not medically necessary.

**Large Ice Pack Pad:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Cold/heat packs

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neck and Upper Back Pain complaints Page(s): 257.

**Decision rationale:** California MTUS guidelines state that "At-home local applications of cold packs during first few days of acute complaints; thereafter, applications of heat packs." This patient has chronic low back pain. Application of ice is only indicated in acute injuries. Therefore, this request for a large ice pack is not considered medically necessary.

**Lunesta Tab 3mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Eszopicione (Lunesta)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG. Lunesta.

**Decision rationale:** The California MTUS guidelines are silent regarding the issue of sleep aids. Therefore, the ODG was referenced. The ODG specifically states regarding Lunesta that this medication is not recommended for long term use. Likewise, weaning has now been appropriately recommended by utilization review. Therefore, this request for Lunesta is not medically necessary.