

<b>Case Number:</b>	CM14-0143101		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	06/07/2007
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	08/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2014

### 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 61-year-old male who reported an injury on June 7, 2007. The mechanism of injury was not provided. On July 22, 2014, the injured worker presented with pain in the lumbar spine and left hip. Upon examination of the lumbar spine, there was tenderness to the paravertebral muscles with spasm noted. This note is handwritten and largely illegible. The diagnoses were lumbar spine sprain/strain, bilateral shoulder sprain/strain, bilateral knee pain, bilateral hand and bilateral wrist pain. The provider recommended Ultram, Zanaflex, and replacement supplies for her interferential stimulation unit. The provider's rationale was not provided. 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:

**Ultram 50 mg, sixty count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 113.

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

**Decision rationale:** 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 should be evident. There was a lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug use behavior, and side effects. The efficacy of the prior use of the medication was not provided. Additionally, the provider's request does not indicate the frequency of the medication in the request as submitted. As such, the request for Ultram 50 mg, sixty count, is not medically necessary or appropriate.

**Zanaflex 4 mg, thirty count:** 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 Muscle Relaxants Page(s): 63.

**Decision rationale:** According to California MTUS Guidelines, muscle relaxants are to be used with caution as a second line option for short term treatment of acute exacerbations. They show no benefit beyond NSAIDs in pain and overall improvement, and efficacy appears to diminish over time. Prolonged use of some medications in this class may lead to dependence. The efficacy of the prior use of the medication was not provided. Additionally, the provider's request does not indicate the frequency of the medication in the request as submitted. As such, the request for Zanaflex 4 mg, thirty count, is not medically necessary or appropriate.

**Replacement supplies for interferential stimulator unit (OS4):** 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 Criteria for the use of TENS Page(s): 116.

**Decision rationale:** The request for Replacement Supplies for Interferential Stimulator Unit (OS4) 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 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 upon physical examination. It is unclear if the injured worker underwent an adequate TENS trial. Additionally, the provider's request does not indicate the site at which the TENS unit is indicated for in the request as submitted. As a TENS unit would not be warranted, the request for replacement supplies for interferential stimulator unit (OS4) is not medically necessary or appropriate.