MAXIMUS Federal Services

| Case Number: | CM14-0099993 | | |
|---|---|---|---|
| Date Assigned: | 09/16/2014 | Date of Injury: | 03/14/2007 |
| Decision Date: | 06/16/2015 | UR Denial Date: | 06/26/2014 |
| Priority: | Standard | Application Received: | 06/30/2014 |

## 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. 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: New Jersey, New York
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 50 year old male, who sustained an industrial injury on 03/14/2007. He has reported subsequent low back and lower extremity pain and was diagnosed with lumbar post laminectomy syndrome, lumbar radiculopathy and chronic pain. Treatment to date has included oral pain medication, physical therapy, lumbar epidural steroid injury and surgery. In a progress note dated 06/17/2014, the injured worker complained of low back pain radiating to the bilateral lower extremities. Objective findings were notable for spasm in the paraspinous musculature L3-L5 level, tenderness to palpation bilaterally at the L3-S1 paravertebral area and bilateral buttocks, decreased range of motion of the lumbar spine and significantly increased pain with flexion and extension. A request for authorization of permanent interferential current stimulation, urine drug screen and Doxepin was submitted.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**1 permanent interferential current stimulation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

**Decision rationale:** The request for ICS is considered not medically necessary. The patient does not meet selection criteria. He is not documented to have failed all conservative therapy. There is no documentation that his pain was not controlled by all classes of medications or he suffered side effects that would prevent him from continuing medications. A one-month trial of ICS that demonstrated increased functional improvement and less pain, with evidence of medication reduction would be necessary before prescribing a permanent unit. Therefore, the request is considered not medically necessary.

**1 urine drug screen:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic) Urine drug testing (UDT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing, Opioids Page(s): 43, 78.

**Decision rationale:** The request for a urine drug screen is considered medically necessary. The patient's medications include opioids and in order to monitor effectively, the 4 A's of opioid monitoring need to be documented. This includes the monitoring for aberrant drug use and behavior. One of the ways to monitor for this is the use of urine drug screens. Therefore, I am reversing the prior UR decision and consider this request to be medically necessary.

**Doxepin 10mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants Page(s): 14-15. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Antidepressants.

**Decision rationale:** The request for Doxepin is not medically necessary. It is a tricyclic antidepressant being used to treat insomnia. TCA are first-line treatment for neuropathic pain accompanied by insomnia and depression, unless they are ineffective, poorly tolerated, or contraindicated. Outcome should be evaluated at one week of treatment with a recommended trial of at least 4 weeks. There is not enough documentation to indicate symptom relief within 4 weeks of use. No psychological assessments were noted. Therefore, the request is considered not medically necessary.