

<b>Case Number:</b>	CM15-0011604		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	11/10/2009
<b>Decision Date:</b>	03/27/2015	<b>UR Denial Date:</b>	12/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care Medicine

### 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 73-year-old male who reported injury on 11/10/2009. The mechanism of injury was the injured worker was driving a 16 passenger bus, when he stopped at a stop light and was struck from behind by a pickup truck. Prior therapies included medications, occupational therapy, the use of a walker, cane, 12 sessions of therapy, a shower chair, a home exercise program, cold and heat pack, Velcro wrist splint, and muscle rub. The injured worker was noted to be approved for a transcutaneous electrical nerve stimulation unit; 6 therapy sessions; and a back brace. The injured worker an anterior cervical C4-5 discectomy and COD decompression on 09/26/2011, and epidural steroid injections on 12/23/2009 and 12/2010. The injured worker underwent a further epidural injection on 01/03/2013. There was a Request for Authorization submitted for review dated 11/12/2013 for a request for a TENS unit and lumbar back support. The prior Request for Authorization was dated 09/10/2014, and it was a request for 9 volt batteries, braces and wraps, EMG/NCV, TENS pads, and replacement. The documentation of 09/10/2014 indicated there was a request for a replacement of the TENS unit pad, hot and cold wrap, and 9 volt batteries. The subsequent documentation of 11/12/2014 indicated the case management had approved a TENS unit. The injured worker's gait was noted to be unstable, and the injured worker had hyperreflexia in the lower extremities. The diagnoses included discogenic cervical condition with facet inflammation; history of myelopathy status post cervical fusion at C4-5; discogenic lumbar condition with facet inflammation and radiculopathy with bilateral foot drop. The treatment plan included a urine drug screen, including creatinine and BUN to check urine function, a TENS unit, physical therapy, an MRI of

the lumbar spine, a CT myelogram; Nalfon 400 mg; and Protonix. Norco #120 was requested also.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**TENS unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114-116.

**Decision rationale:** The California Medical Treatment Utilization Schedule recommends a one 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 three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. The clinical documentation submitted for review indicated the injured worker had a TENS unit. There was a lack of documentation indicating objective functional benefit and an objective decrease in pain with the unit. There was a lack of documentation indicating the injured worker would be utilizing the unit as an adjunct to a program of evidence based functional restoration for chronic neuropathic pain. The request as submitted failed to indicate whether the unit was for rental or purchase. Given the above, the request for a TENS unit is not medically necessary.

**Norco (dosage not specified) #120 DOS 11/12/14:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75-80, 91 and 124.

**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. There should be documentation of objective functional improvement; and objective decrease in pain; and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to meet the above criteria. There was a lack of documentation per the submitted request, to include the frequency and dosage for the requested medication. Given the above, the request for Norco, (dosage not specified), #120, DOS 11/12/2014 is not medically necessary.

**Nalfon 400mg #60 DOS 11/12/14:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68 & 71.

**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 low back pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and an objective decrease in pain. The duration of use could not be established. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Nalfon 400 mg #60 DOS 11/12/2014 is not medically necessary.

**Protonix 20mg #60 DOS 11/12/14:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 68-69.

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend proton pump inhibitors for injured workers who are at intermediate or high risk for gastrointestinal events. The clinical documentation submitted for this review failed to indicate the injured worker was at intermediate or high risk for gastrointestinal events. The request as submitted failed to indicate the frequency. Additionally, this medication was being concurrently reviewed with an NSAID, which was not supported. As such, there would be no necessity for the requested medication. The efficacy was not provided. Given the above, the request for Protonix 20 mg #60 DOS 11/12/2014 is not medically necessary.

**10 panel urine screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77-80 & 94.

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend periodic monitoring of liver and kidney function testing for all injured workers taking long term NSAIDs. The clinical documentation submitted for review failed to indicate the duration of use for the medications. The request as submitted failed to indicate the components for the requested 10 panel urine screen. There was documented rationale. Given

the above and the lack of documentation indicating the components for the 10 panel urine screen, the request for a 10 panel urine screen is not medically necessary.