

<b>Case Number:</b>	CM15-0112824		
<b>Date Assigned:</b>	07/22/2015	<b>Date of Injury:</b>	06/12/2002
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	05/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2015

### 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: Texas, California

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 48 year old male, who sustained an industrial injury on 6/12/02. The injured worker was diagnosed as having lumbar radiculitis, lumbar post laminectomy syndrome, status post spinal cord stimulator, gastritis secondary to NSAIDs (non-steroidal anti-inflammatory drugs) and depression. Treatment to date has included oral medications including Norco 10/325mg, Ibuprofen 800mg #90, Prilosec 20mg and Ambien 10mg; spinal cord stimulator and activity restrictions. Currently on 4/17/15, the injured worker complains of low back pain with radiation to legs and poor sleep, he rates the pain 4/10 on average, 8/10 without meds, best 3/10 and 6/10 worst. Pain levels are unchanged since previous visit dated 3/20/15. Objective findings on 4/17/15 revealed decreased range of motion, positive paravertebral tenderness and positive straight leg raise. The treatment plan included request for refill of medications, Transcutaneous electrical nerve stimulation (TENS) unit supplies, urine toxicology screen next visit and follow up appointment. The medication list include Norco, Ambien, Neurontin, Prilosec and Ibuprofen. The patient has had UDS on 7/2014 that was inconsistent for Hydrocodone and Ambien and it was consistent on 4/2015. The patient has had history of gastritis secondary to medication. The patient has had history of depression, difficulty in sleeping and mood disorder. A recent detailed psychological or psychiatric evaluation note of the psychiatrist was not specified in the records provided. The patient had received an unspecified number of PT visits for this injury.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transcutaneous electrical nerve stimulation (TENS) unit and supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation); Criteria for the use of TENS Page(s): 114-115, 116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) page 114 Page(s): 114-116.

**Decision rationale:** Request: Transcutaneous electrical nerve stimulation (TENS) unit and supplies. According the cited guidelines, electrical stimulation (TENS), is not recommended as a primary treatment modality, but a one-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, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Recommendations by types of pain: A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use). According the cited guidelines, Criteria for the use of TENS is "There is evidence that other appropriate pain modalities have been tried (including medication) and failed." A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. Any evidence of neuropathic pain, CRPS I and CRPS II was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. A detailed response to previous conservative therapy was not specified in the records provided. Previous conservative therapy notes were not specified in the records provided. In addition a treatment plan including the specific short- and long-term goals of treatment with the TENS unit was not specified in the records provided. The records provided did not specify any recent physical therapy with active PT modalities or a plan to use TENS as an adjunct to a program of evidence-based functional restoration. Any evidence of diminished effectiveness of medications to medications was not specified in the records provided. The medical necessity of the TENS unit is not fully established and therefore the need for the TENS unit supplies is also not established. The medical necessity of request for Transcutaneous electrical nerve stimulation (TENS) unit and supplies is not fully established for this patient.

**Ambien 10mg, #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain (updated 09/08/15) Zolpidem is a short-acting non-benzodiazepine hypnotic.

**Decision rationale:** Ambien 10mg, #30: The California MTUS/ACOEM Guidelines do not address this medication; therefore, ODG was utilized. According to the cited guideline "Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia." A detailed history of anxiety or insomnia was not specified in the records provided. A trial of other measures for treatment of insomnia is not specified in the records provided. A detailed evaluation by a psychiatrist for stress related conditions is not specified in the records provided. Per the cited guideline use of the Zolpidem can be habit-forming, and it may impair function and memory more than opioid pain relievers. The medical necessity of the request for prescription of Ambien 10mg, #30 is not fully established for this patient, given the records provided and the guidelines cited. When discontinuing a this medication, it is recommended that it should be tapered over time according to the discretion of the treating provider to prevent withdrawal symptoms.