

<b>Case Number:</b>	CM15-0172311		
<b>Date Assigned:</b>	09/14/2015	<b>Date of Injury:</b>	08/15/2011
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	08/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/01/2015

### 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: Tennessee, Florida, Ohio  
 Certification(s)/Specialty: Surgery, Surgical Critical Care

### 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 46 year old male, who sustained an industrial injury on August 15, 2011. Medical records indicate that the injured worker is undergoing treatment for axial neck pain, low back pain with radicular pain in the right leg, lumbosacral radiculopathy, congenital spondylolisthesis of the lumbosacral region, lumbosacral spondylosis without myelopathy, lumbar or lumbosacral intervertebral disc degeneration and chronic pain syndrome. Associated with the chronic pain syndrome the injured worker was noted to have weight gain, sexual dysfunction, sleep disorder and depression. The injured worker was working full time with restrictions. Current documentation dated August 3, 2015 notes the injured worker had neck pain which was not giving him major limitations. There was no radiculopathy noted. The injured worker also noted low back pain with sitting, standing and walking tolerance of no more than 30 minutes. Examination of the lumbar spine revealed tenderness along the lumbosacral area and a decreased range of motion. Facet loading and a straight leg raise test were positive. Sensation was diminished along the lateral thigh on the right. Treatment and evaluation to date has included medications, lumbar x-rays, computed tomography scan, MRI, lumbar epidural steroid injections, back brace and a two-lead transcutaneous electrical nerve stimulation unit. Failed conservative treatment includes physical therapy, medication and injections. Current medications include Celebrex, Protonix (since April of 2015), Tramadol ER, Neurontin, Flexeril (since April of 2015), Effexor and Trazadone. The treating physician's request for authorization dated August 3, 2015 includes requests for one conductive garment, Protonix 20 mg # 30, Flexeril 7.5 mg # 60, Effexor XR 75 mg # 60, cognitive behavior therapy (sessions unknown) and a four-lead

transcutaneous electrical nerve stimulation unit. The Utilization Review documentation dated August 18, 2015 non-certified the requests for one conductive garment, Protonix 20 mg # 30, Flexeril 7.5 mg # 60, Effexor XR 75 mg # 60, cognitive behavior therapy (sessions unknown) and a four-lead transcutaneous electrical nerve stimulation unit.

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

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

#### **1 Conductive garment: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. California MTUS guidelines for Chronic Pain Management state that per the TENS section, a form fitting conductive device is considered medically necessary when there is documentation that a large area requires stimulation that a conventional system cannot accommodate the treatment. Clinical documentation submitted for review failed to provide the necessity for the requested service including a 4 lead TENS unit. Given the above, the request for conductive garment purchase is not medically necessary. Therefore, based on the submitted medical documentation, the request for a conductive garment is not medically necessary.

#### **Protonix 20mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chronic: Proton pump inhibitors (PPIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of the requested prescription for this patient. The clinical records submitted do not support the fact that this patient has refractory GERD resistant to H2 blocker therapy or an active h. pylori infection. The California MTUS guidelines address the topic of proton pump prescription. In accordance with California MTUS guidelines, PPI's (Proton Pump Inhibitors) can be utilized if the patient is concomitantly on NSAIDs and if the patient has gastrointestinal risk factors. This patient is not on NSAIDs. Additionally, per the Federal Drug Administration's (FDA) prescribing guidelines for PPI use, chronic use of a proton pump inhibitor is not recommended due to the risk of developing atrophic gastritis. Short-term GERD symptoms may be controlled effectively with an H2 blocker unless a specific indication for a

proton pump inhibitor exists. This patient's medical records have no documentation of why chronic PPI therapy is necessary. The patient does not have GERD which has been documented to be refractory to H2 blocker therapy and he has not records that indicate an active h. pylori infection. Therefore, based on the submitted medical documentation, the request for Protonix prescription is not medically necessary.

**Flexeril 7.5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. In accordance with the California MTUS guidelines, Cyclobenzaprine is a muscle relaxant and muscle relaxants are not recommended for the treatment of chronic pain. From the MTUS guidelines: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic back pain". Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence." This patient has been diagnosed with chronic pain syndrome related to back pain of the cervical and upper spine. Per MTUS, the use of a muscle relaxant is not indicated for long-term pain control. Therefore, based on the submitted medical documentation, the request for Cyclobenzaprine is not-medically necessary.

**Effexor XR 75mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Stress-Related Conditions 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & stress: Antidepressants for treatment of Major Depressive Disorder.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of an Effexor prescription for this patient. Effexor is the name brand equivalent of generic Venlafaxine. The clinical records submitted do support the fact that this patient has chronic depression. However, the medical records do not support that this patient has a refractory major depressive disorder with supervision by a specialist. The California MTUS guidelines do address the topic of Effexor prescription. Specifically, per MTUS, "Effexor is a member of the selective-serotonin and norepinephrine reuptake inhibitor (SNRIs) class of antidepressants. It has FDA approval for treatment of depression and anxiety disorders." Additionally, "Antidepressant or antipsychotic medication may be prescribed for major depression or psychosis; however, this is best done in conjunction with specialty referral." This patient has been diagnosed with depression; however, the clinical records indicate that he

continues to have severe depression despite multiple medications. Management of clinical depression is best done with a specialist. Despite his persistent depression, there is no evidence this patient is being treated by a specialist. Furthermore, although Effexor may be used for the treatment of chronic pain per MTUS guidelines, there is no indication that it has been prescribed for this indication. Therefore, based on the submitted medical documentation, the request for Effexor prescription is not-medically necessary.

**Cognitive behavioral therapy (unknown number of sessions): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cognitive Behavioral Therapy for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The California MTUS guidelines state that "For cognitive behavioral therapy (CBT), an initial trial of 3 to 4 psychotherapy treatments over 2 weeks and additional treatments for a total of 6 to 10 visits with documented functional improvement." Although this patient has had a history of prior psychological treatment, he is currently maintained on medication that is reported as helping treat his symptoms. The patient's clinical documentation does not state the number of requested CBT treatments prescribed. CBT therapy is only indicated for a set period of time to assess for improvement prior to continuation of therapy. Therefore, based on the submitted medical documentation, the request for cognitive behavioral therapy is not-medically necessary.

**4 Lead TENS unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of a 4 lead TENS unit for this patient. The 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 criteria since no treatment plan (that includes short and long term goals) was submitted to indicate why a 4 lead TENS unit was necessary over the patient's current 2 lead TENS unit. Therefore, based on the submitted medical documentation, the request for TENS unit is not-medically necessary.