

<b>Case Number:</b>	CM13-0069407		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	09/27/2007
<b>Decision Date:</b>	06/02/2014	<b>UR Denial Date:</b>	12/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2013

### 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 Anesthesiology and Pain Medicine, and is licensed to practice in California. 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 55-year-old female who reported an injury on 9/27/07 due to assault by a co-worker. The injured worker's treatment history included physical therapy, dental repair, psychological support, and multiple medications. The injured worker was evaluated on 10/24/13. It was documented that she had continued neck pain, back pain, bilateral shoulder pain, bilateral wrist pain, and emotional distress secondary to the industrial incident. Physical findings included tenderness to palpation over the paraspinal musculature of the cervical spine with a negative Spurling's sign, and tenderness to palpation over the lumbar paraspinal musculature with spasm noted. The injured worker's diagnoses included cervical spine strain/sprain, lumbar spine strain/sprain, status post bilateral carpal tunnel release, right shoulder sprain/strain with subacromial impingement, anxiety, depression, insomnia, fibromyalgia, left shoulder sprain/strain, and temporomandibular joint dysfunction. Her treatment plan included a psychological evaluation, continuation of medications, and continuation of aquatic therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NEXWAVE STIM UNIT RENTAL FOR THREE (3) MONTHS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** The California MTUS recommends a TENS unit as an adjunct treatment to an active functional restoration program. There is no recent clinical documentation to support that the injured worker is participating in a home exercise program or other type of active therapy that would benefit from the adjunct treatment of a TENS unit. Additionally, the MTUS recommends a 30 day clinical trial that produces functional benefit and pain relief before the unit can be requested for longer periods of time. The clinical documentation submitted for review does not provide any evidence that the injured worker has undergone a 30 day clinical trial to support additional treatment. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested Nexwave stim unit rental for 3 months is not medically necessary or appropriate.

**ELECTRODES THREE (3) MONTH SUPPLY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**BATTERIES THREE (3) MONTH SUPPLY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.