

Case Number:	CM14-0005494		
Date Assigned:	01/24/2014	Date of Injury:	12/09/2010
Decision Date:	06/12/2014	UR Denial Date:	01/14/2014
Priority:	Standard	Application Received:	01/15/2014

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. The expert reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in Mississippi. 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 record notes a 54-year-old individual with a date of injury of December 9, 2010. The mechanism of injury is not disclosed. The record indicates that the claimant is status post anterior cervical discectomy at C5-6 with spinal cord decompression, and anterior, C5-6 disc arthroplasty with prestige artificial cervical disc on January 25, 2013. The diagnoses include chronic neck pain, cervical disc herniations, and radiculopathy in the bilateral upper extremities. The treatment has included physical therapy, pharmacotherapy, massage, electrical stimulation (during physical therapy with benefit.). A cervical spine x-ray dated November 20, 2013 demonstrates no instability with noted hardware at C5-6 and a progressing fusion. A progress note dated January 3, 2014 indicates a complaint of severe itching and pain in the left upper extremity following surgery, though other radiculopathy symptoms were relieved with the surgery. The pain was rated 7/10 and constant. A letter of medical necessity dated December 27, 2013 is provided indicating a necessity for purchase of a GSM transcutaneous electrical nerve stimulation (TENS) unit, 4 lead, no substitution, for pain control and edema. A pain rating of 5-8/10 is reported. The most recent progress note available for review is dated November 26, 2013 and notes that the claimant continues to experience "excruciating pain" in the left upper arm, rated 7-8/10. The right upper extremity burning pain is improved. Recurrent pain down to the median innervated fingers of the left hand and left shoulder is reported. A new symptom of swollen ankles is noted. The record indicates that the claimant underwent consultation at the [REDACTED], where it was recommended that the claimant be evaluated by an allergist due to the possibility of an allergy to artificial disc. The claimant was to receive massage therapy at [REDACTED], but had a bad experience and would prefer to go elsewhere. Normal blood tests were provided 4 months prior. The claimant has been approved for pool therapy; however, it is 20 miles from her home and therefore she has not attended.

Physical examination reveals restricted range of motion of the cervical spine. Palpation of the left side of the neck causes pain radiating down the left arm. A positive Spurling's test was noted, strength is slightly reduced with resistance of the left shoulder, elbow, and wrist. Deep tendon reflexes reveal a right biceps of 1+ and the left biceps is graded at trace and the bilateral triceps are also trace. The treatment recommendation is for referral to an allergist, pool therapy, and change to a different therapist. Electromyography (EMG) from August 2013 evidence mild chronic CA, and T1 radiculopathies affecting the right upper extremity, and a possible C7 radiculopathy affecting the right upper extremity. This request for a GMS HD combo TENS unit with HAN for purchase and supplies was previously non-certified on January 14, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

GMS HD COMBO TENS UNIT WITH HAN FOR PURCHASE AND SUPPLIES(ELECTRODES X 8 PAIRS PER MONTH FOR 3 MONTHS AND BATTERIES X 6 AAA PER MONTH FOR THREE MONTHS): Upheld

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

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

Decision rationale: The MTUS recommends against using a transcutaneous electrical nerve stimulation (TENS) unit as a primary treatment modality and indicates that a one-month trial must be documented prior to purchase of the unit. Based on the clinical documentation provided, I have been unable to identify at which point the TENS unit was recommended, as it is not referenced in any of the physician notes available. Additionally, the record provides no documentation that a 30 day one-month trial was previously certified, and the required documentation of a positive response to that 30 day trial is not noted. As such, this request for purchase of a TENS unit is recommended for non-certification.