

<b>Case Number:</b>	CM14-0108266		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	07/19/2012
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	07/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/11/2014

### **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 Physical Medicine & Rehabilitation, 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 52-year-old male who reported injury on 07/19/2012. The mechanism of injury was a motor vehicle accident. The diagnostic studies were noted to include a CT scan of the cervical spine, and urine drug screens. The prior procedures included a vertebral corpectomy, partial anterior approach with decompression of spinal cord at C4, C5 and anterior instrumentation at C4 and C5 with the application of a biomechanical device at C4-5 and an arthrodesis on 10/17/2013. The injured worker underwent a selective cervical epidural steroid injection C4 through C6 on 03/19/2013. Other therapies included physical therapy and pool therapy. The injured worker underwent x-rays. The documentation of 07/01/2014 revealed the injured worker had subjective complaints of constant, moderate to severe pain and discomfort in the cervical spine that was stabbing and "horrible" in nature. The injured worker had similar constant and intense pain in the right shoulder and bilateral hands. The injured worker's medications were noted to include Percocet 10/325 mg and Tizanidine/Zanaflex 4 mg. The objective findings revealed tenderness to palpation over the cervical spine and decreased range of motion of the cervical spine, right shoulder and lumbar spine. The diagnoses included musculoligamentous sprain cervical spine, status post cervical spine fusion, possible new and further pathology at the fusion site cervical spine, possible internal derangement brachial plexus, musculoligamentous sprain, thoracic spine, radiculopathy right upper extremity, and degenerative disc disease of the lumbar spine as well musculoligamentous sprain and the lumbar spine. The discussion portion indicated the injured worker began to experience numbness in the right arm and increasing severe neck pain of approximately 10 days prior to the examination.

The injured worker's pain was a 9/10 which was increased from 4/10 to 5/10 one month previously. The injured worker underwent a CT of the cervical spine previously. The treatment plan included an MRI of the brachial plexus, cervical spine, Prilosec, Zanaflex, a home exercise kit, a TENS unit, and an ice and heat unit. The rationale for the ThermoCool Cold Contrast Therapy Unit was for a period of 60 days for pain control, reduction of inflammation and increased circulation for the shoulder and cervical spine.

### **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 Page(s): 114-116.

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

**Decision rationale:** The California MTUS Guidelines recommend 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 3 months of pain and evidence that other pain modalities including medications have trialed and failed. The clinical documentation submitted for review failed to meet the above criteria. The request as submitted failed to indicate whether the unit was for rental or purchase. Given the above, the request for TENS unit is not medically necessary.

**Electrodes per each month Qty:3:** Upheld

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

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

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

**Lead wires per each month qty:3:** Upheld

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

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

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

**Replacement batteries per each month qty:3:** Upheld

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

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

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

**Cold Therapy recovery system Qty:1:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Neck & Upper Back Chapter, Continuous Flow Cryotherapy.

**Decision rationale:** The Official Disability Guidelines indicate that continuous full cryotherapy is appropriate postoperatively for treatment of the shoulder. It is not recommended for treatment of the neck and cervical spine. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. The request as submitted failed to indicate the frequency and the duration of use. The request as submitted failed to indicate whether the unit was for rental or purchase. Given the above, the request for cold therapy recovery system quantity 1 is not medically necessary.

**Pad for water circulating:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Neck & Upper Back Chapter, Continuous Flow Cryotherapy.

**Decision rationale:** Since the Cold Therapy System is not medically necessary, none of the associated services are medically necessary.