

<b>Case Number:</b>	CM14-0167312		
<b>Date Assigned:</b>	10/14/2014	<b>Date of Injury:</b>	11/09/2012
<b>Decision Date:</b>	11/17/2014	<b>UR Denial Date:</b>	10/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/10/2014

### 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 Internal 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 (IW) is a 60-year old man who worked as a truck driver for [REDACTED]. He denied any specific physical injury at work. He reports cumulative trauma resulting in pain in his left leg, arm, back, and neck. He has not undergone surgery. Upon review of the medical records, there were various dates of injury, the initial documented on September 12, 2007. At that time, his truck was struck by another vehicle. He received conservative treatment and returned to work approximately 6 weeks later. The IW had an Orthopedic Panel Qualified Medical Evaluation on January 13, 2014. The IW began experiencing pain in his lower back and left lower extremity again in 2010. He reports that he did not report this to his employer, but sought care at Kaiser Permanente, his personal insurance. He then reported this to his employer, and was referred to industrial care. He received conservative treatment, which included a lumbar epidural injection. Current complaints include neck pain, left shoulder pain, left elbow, left hand with numbness in all fingers except the thumb, and upper and lower back pain with tingling sensation in the left leg and foot. Current medications are: Naprosyn 550mg, Lisinopril 5mg, Gabapentin 100mg, Alprazolam, Hydrochlorothiazide 25mg, and Terazosin 5mg. Based on the nature of the complaints and findings, it is documented that the IW will require continued pain management, medications, short periods of physical therapy, for his neck, back, and shoulder. He is not considered to require surgical intervention at this time; however, lumbar or cervical epidurals should be available to him, should they be necessary. As a result of his injuries, the IW suffered losses of health, self-esteem and self-worth. He lost his ability to experience pleasure, enjoy activities, and engage in the community of family and friends. Because of these losses, the IW sustained a number of psychiatric symptoms. A Psychiatric Panel Qualified Medical Evaluation was completed on September 21, 2013.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**DME: Pro- Stim Unit x 3 months rental, and 3 months supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

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

**Decision rationale:** Pursuant to the California MTUS Chronic Pain Medical Treatment Guidelines to Pro-Stim (TENS unit) and three month supplies are not medically necessary. The Tens unit for chronic pain is not recommended as a primary treatment modality, but a one month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct or program of evidence-based functional restoration. The results of TENS unit applications are inconclusive. Evidence is lacking concerning effectiveness. Criteria for the use of TENS include: documentation of paying at least three months duration; there is evidence that other appropriate pain modalities have been tried, including medication, and failed; a one month trial should be documented; other ongoing pain treatment should be documented during the TENS trial, including medication; a treatment plan including specific short and long-term goals of treatment with the tens unit should be submitted. In this case, the request for a three month rental and three month supply are not medically necessary. The criteria noted above allow for a one month trial of the TENS unit. Additionally specific short and long-term goals of treatment with the TENS unit should be submitted. The requesting physician ordered a three month TENS unit trial and there were no specific short and long-term goals documented in the medical record. Based on the clinical information in the medical record and the peer-reviewed, evidence-based guidelines, the TENS unit three month rental and three months supplies are not medically necessary.

**DME: [REDACTED] Infrared Heating Pad for purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines IF Unit.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back Complaints, Infrared Therapy

**Decision rationale:** Pursuant to the Official Disability Guidelines solar care infrared heating pad is not medically necessary. The guidelines state infrared therapy is not recommended over other heat therapies. It is not recommended as an isolated intervention in the guidelines. Additionally, there is no quality evidence of effectiveness except in conjunction with the recommended treatments including return to work, exercise and medications with limited evidence of improvement with those previously noted treatments. Because there were no other conservative measures undertaken the requester infrared unit is not medically necessary. Based on the clinical

information in the medical record and the peer-reviewed, evidence-based guidelines, Infrared therapy is not medically necessary.