

<b>Case Number:</b>	CM14-0034786		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	10/13/2013
<b>Decision Date:</b>	08/18/2014	<b>UR Denial Date:</b>	03/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/20/2014

### 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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 21-year-old female who reported an injury on 10/13/2013, due to a fall at work, where she struck her left arm, left ribs, left leg, and head against a metal object. The injured worker was sent to the hospital per her supervisor, and received a CT scan and medications. The result of the CT scan is not documented and the medications given at that time also were undocumented. The injured worker then went to her company clinic, where she received pain medications, physical therapy, and injections for the neck muscles to help with headaches. These medications were not specified elsewhere. The injured worker saw her physician on 12/20/2013. She complained of left side rib pain at 6/10, radiating to her back. There was no numbness or tingling. Pain increased with activity. She stated she had left leg discomfort with tingling, but no pain. She reports constant headaches rated at 8/10 - 9/10, with pain radiating to the left arm. The injured worker noted tingling in the fingers of her left hand. She reports severe headaches causing nausea and vomiting. She further states she has limited activities of daily living due to pain and headaches. She reported to her physician her medications. She only takes ibuprofen as medication. The physician noted a normal gait. Orthopedic studies included a positive compression, Spurling, and distraction test. The physician notes the numbness to the left fingertips. The physician diagnosed the injured worker with headaches, rule out post-concussion syndrome; closed head trauma without loss of consciousness, rule out post-concussion syndrome; left chest wall pain; gastritis; left upper extremity neuropathy; and left lower extremity radiculopathy. The physician prescribed Gabapentin, Tramadol, Cyclobenzaprine, Pantoprazole, and Transderm patches. The physician issues a return to work form with restrictions stating she can only perform light duties. The physician saw the injured worker on 02/04/2014, where the injured worker reports headaches lasting 3 days with nausea, vomiting, and decreased blood pressure. The physician notes the

injured worker is in a state of anxiety, stress, and depression. The physician reviewed an MRI of the brain and cervical spine taken on 01/28/2014. The physician made no comment on the results. The physician will continue the injured worker on physical therapy, acupuncture, and functional restoration programs. The physician will seek a range of motion and muscle strengthening test. Medications remain the same. The physician saw the injured worker on the final visit of 03/21/2014. The injured worker returned with the same complaints and levels of pain. The physician, after assessing the injured worker, added these diagnoses to the current list, including migraine headaches, cerebellar tonsillar ectopia, aeration of left anterior clinoid process in the brain, and pregnancy. The physician did not reissue any medications on this visit, and a drug urine test was collected. The physician is seeking an IF unit with supplies and a thermal cooling system for the injured worker. There was no rationale provided for either system. The request for authorization forms were not provided for review in these documents.

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

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

**IF Unit with supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

**Decision rationale:** An IF unit is also known as a TENS (Transcutaneous Electric Nerve Stimulation) unit. The California MTUS Guidelines does not recommend TENS (Transcutaneous Electric Nerve Stimulation) units as a primary treatment modality, but a 1 month home based TENS (Transcutaneous Electric Nerve Stimulation) trial may be considered as a noninvasive conservative option, if as adjunct to a program of evidence based function restoration for the conditions described below: (a) Documentation of pain of at least 3 months duration, (b) There is evidence that other appropriate pain modalities have been tried including medication and failed, (c) A 1 month trial period of a TENS (Transcutaneous Electric Nerve Stimulation) unit should be documented, (d) Other ongoing pain treatment should be documented during the trial period including medication use, (e) A treatment plan including specific short and long term goals of treatment with a TENS (Transcutaneous Electric Nerve Stimulation) unit should be submitted, and (f) A 2 lead unit is generally recommended; if a 4 lead unit is recommended, there must be documentation why this is necessary. The request for the IF unit with supplies does not specify length of use nor placement indicating a longer than accepted use for MTUS guidelines. There has been documentation of pain over the last 3 months. Pain medications, physical therapy, and acupuncture have all failed during this time. There was no treatment plan including the specific short and long term goals of treatment with a TENS unit. As such, the request of IF (Interferential) Unit with supplies is not medically necessary and appropriate.

**Therma Cooling System:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

**Decision rationale:** ODG guidelines for continuous flow cryotherapy do not recommend use of this for the neck, but does approve it for the shoulder and for the leg postsurgically. The physician has not indicated where the application of this cooling system would be. ODG guidelines are very limited on their recommendations of this device. As such, the request of Therma Cooling System is not medically necessary and appropriate.