

<b>Case Number:</b>	CM14-0085214		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	11/11/2013
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	05/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/06/2014

### 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 and Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 48-year-old male who reported an injury on 11/11/2013. The mechanism of injury was a mechanical fall from a 10-foot ladder at work. The surgical history was noncontributory. The diagnostic studies were not provided. The documentation of 04/01/2014 revealed the injured worker had complaints of right shoulder pain, right wrist pain, left wrist pain, low back pain, and left leg pain as well as inguinal pain when his bladder is full. The injured worker complained of buzzing in the ears. The physical examination of the lumbar spine revealed the injured worker had a positive straight leg raise at 45 degrees bilaterally. The injured worker had decreased strength at 2+/5. The sensation and reflexes were noted to be equal, symmetrical, and intact. The injured worker had decreased range of motion of the right shoulder, a positive impingement, apprehension sign, and crepitus. The strength was 2+/5. The injured worker had decreased range of motion of the right wrist and hand and mild inflammation and tenderness to palpation of the right wrist joint. The injured worker had decreased range of motion of the right wrist. The strength was 2+/5, and there was no tenderness to palpation. Jamar testing in the right hand was 0 kg. The diagnosis included tension headaches, gastritis, abdominal pain, and cervical spine and lumbar spine as well as right shoulder sprain and strain. The treatment plan included chiropractic treatments with physiotherapy 2 times a week times 4 weeks, acupuncture, an MRI of the lumbar spine and right shoulder, a CT of the right wrist, an EMG/NCV of the bilateral upper and lower extremities, a psychological consultation, and an ENT consultation as well as a TENS/multistim unit and a hot and cold pack wrap or thermal combo unit including a Vascutherm 4 DVT system. The medications that were prescribed included Naproxen 550 mg, Diazepam 5 mg, Pantoprazole, and Transdermal Compounds. There was no Request for Authorization form submitted for the request.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **DME (Durable Medical Equipment): Aqua Relief System: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- TWC Low Back Procedure Summary last updated 03/12/2013; Frontera: Essentials of Physical Medicine and Rehabilitation, 1st ed. Chapter 104-Deep Vein Thrombosis.

**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, Continuous Flow Cryotherapy.

**Decision rationale:** The Official Disability Guidelines indicate that a continuous flow cryotherapy system is medically appropriate for postsurgical treatment for up to 7 days. There was lack of documentation indicating the injured worker would be having surgical intervention. The request as submitted failed to indicate the duration of use and whether the unit was for rental or purchase. Given the above, the request for DME (durable medical equipment) aqua relief system is not medically necessary.

### **Home trial of TENS unit with electrodes, batteries, wire supplies: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy; TENS, chronic pain (transcutaneous electrical nerve stimulation).

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

**Decision rationale:** The California MTUS Guidelines recommend a 1 month trial of as a TENS unit as an adjunct to a program of evidence based functional restoration program for chronic neuropathic pain. Prior to the trial, there must be documentation of at least 3 months of pain and evidence that other appropriate modalities have been trialed and failed including medications. The clinical documentation submitted for review failed to meet the above criteria. There was a lack of documentation indicating the unit would be utilized as an adjunct to a program of functional restoration. Given the above, the request for home trial of a TENS unit with electrodes, batteries, and wire supplies is not medically necessary. Additionally, the request as submitted failed to indicate whether the unit was for rental or purchase and the length of the trial.