

<b>Case Number:</b>	CM14-0137867		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	05/04/2014
<b>Decision Date:</b>	01/16/2015	<b>UR Denial Date:</b>	08/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2014

### 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 Family 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:

This injured worker's date of injury is 05/04/2014. This patient receives treatment for chronic neck pain. The original injury occurred when the patient lost his grip, fell backwards and struck the head. Initial diagnosis was concussion, with neck and back injuries. The medical documentation provided consists of a DWC Form PR-2 request for services. The patient has dull, sharp headaches, dull, sharp neck pain, dull, sharp thoracic backache, and has depression, anxiety, and irritability. On exam the neck ROM is reduced. There are tender muscle spasms in the neck. The medical diagnoses include: headache, cervical radiculopathy, anxiety, depression, and nervousness. MRI imaging of the brain and thoracic spine are normal.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home TENS unit and supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114.

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

**Decision rationale:** The TENS unit may be medically indicated for post-operative pain in limited settings, such as, phantom limb pain, neuropathy, spasticity, or as an isolated intervention

if certain criteria is met. A one month trial must clearly show benefit and documentation must include a treatment plan with short and long term goals. The documentation does not cover any of these facts. TENS is not medically indicated.

**Functional Capacity Evaluation: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Functional Capacity Evaluations (FCE)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness of Duty, Functional Capacity Evaluation

**Decision rationale:** The ODG recommends an FCE if there is evidence of prior unsuccessful attempts to return to work or if there are conflicting medical precautions for a modified job. There is no such documentation. An FCE is not medically indicated.

**EMG/NCV bilateral upper extremities: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Electrodiagnostics studies

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 262.

**Decision rationale:** The treating clinician's documentation of the history and the physical exam does not indicate that the patient has a true compression neuropathy. Electrodiagnostic testing may be medically indicated to distinguish between CTS and other conditions, such as cervical radiculopathy. There is no basis for requesting an EMG/NCV for this patient.

**Localized Intense Neurostimulation Therapy (LINT) x 6 to thoracic spine: 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 Electrical stimulators (E-stim) Page(s): 45-46.

**Decision rationale:** The clinician's documentation is not clear what the actual diagnosis is to be treated with LINT. This treatment, LINT, is not recommended by the ODG or MTUS guidelines, as clinical trials fail to find evidence of any effectiveness to treat chronic pain. LINT treatment is not medically indicated.

**Psych consultation: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

**Decision rationale:** The medical documentation mentions certain symptoms, such as, nervousness and irritability, but there is no further definition of the clinical problem. There is no discussion of mood, cognitive function, memory, or activity. There is no PHQ-9, for example, which is a well recognized screening tool and inventory of mood and thought disorders. The request for "Psych" does not distinguish between a psychologist or a psychiatrist. A Psych consult is not medically indicated.