

<b>Case Number:</b>	CM15-0136076		
<b>Date Assigned:</b>	07/24/2015	<b>Date of Injury:</b>	02/27/2004
<b>Decision Date:</b>	08/20/2015	<b>UR Denial Date:</b>	07/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Emergency Medicine

### 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 47 year old male who sustained an industrial /work injury on 2/27/04. He reported an initial complaint of neck and lower back pain. The injured worker was diagnosed as having mild degenerative disc disease, moderate spondylosis of uncovertebral joints of the cervical spine at C4-5, C5-6, and C6-7, and bilateral upper extremity radiculitis, degenerative disc disease of the lumbar spine at L3-4 and L4-5. Treatment to date includes medication, diagnostics, and surgery (anterior and posterior fusion without spinal canal decompression, removal of spinal cord stimulator). Currently, the injured worker complained of increased chronic low back pain, bilateral leg, and neck pain. Per the primary physician's report (PR-2) on 6/24/15, exam noted restricted range of motion to cervical spine, mild to moderate tenderness with palpation over the cervical spinous processes at the base of the neck, right paraspinal muscles with minimal tenderness over the nerve roots. Upper extremity exam notes deep tendon reflexes are trace + symmetrical at the biceps, 1+ symmetrical at the triceps, strength at 5/5. Lumbar spine exam notes restricted range of motion, surgical scars, and moderate in the right paraspinal muscles and over the left/right sciatic nerve. Lower extremity exam notes 1+ symmetrical reflexes, 5/5 motor strength, positive straight leg raise bilaterally at 60 degrees, R>L. The requested treatments include TENS (transcutaneous electrical nerve stimulation) unit batteries, lead wires, electrodes, 3 month supply (EMPI brand) and Pain Management Evaluation for Class II Narcotics and Cervical Injections.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS (transcutaneous electrical nerve stimulation) unit batteries, lead wires, electrodes, 3 month supply (EMPI brand): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

**Decision rationale:** As per MTUS Chronic pain guidelines, TENS (Transcutaneous Electrical Nerve Stimulation) may be recommended only if it meets criteria. Evidence for its efficacy is poor. Pt does not meet criteria to recommend TENS. TENS is recommended if used with functional restoration program but in this case, there is no documentation of such a program. There is no documented short and long-term goal for the TENS. There is no documentation of any objective pain improvement or function with current use of TENS with persistent severe pain and limitation. Patient has reported subjective improvement only and current documentation does not support a successful 1-month trial of TENS much less continued use. Pt does not meet any criteria to recommend TENS. TENS and supplies related to it is not medically necessary.

**Pain Management Evaluation for Class II Narcotics and Cervical Injections: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 1 Prevention Page(s): 1 and 92.

**Decision rationale:** As per ACOEM and MTUS guidelines, referrals may be appropriate if the caretaker is not able to manage patient's pain and function beyond their capability and after failure of conservative management. Provider provides justification for referral. Patient has been receiving opioids from family provider but requesting provider believes that patient's chronic pain and opioid therapy may be better served by a pain management specialist. There is also a request for specialist to assess patient for potential injections for pain control. An initial evaluation by pain management specialist for assessment of patient's pain medication regimen and potential need for procedures is medically necessary.