

Case Number:	CM15-0185926		
Date Assigned:	09/28/2015	Date of Injury:	08/22/2004
Decision Date:	11/10/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	09/21/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 57 year old female with an industrial injury dated 08-22-2004. A review of the medical records indicates that the injured worker is undergoing treatment for displacement of cervical intervertebral disc without myelopathy, displacement of lumbar intervertebral disc without myelopathy, other affections of shoulder region, not elsewhere, and brachial neuritis or radiculitis nos. According to the progress note dated 08-06-2015, the injured worker presented for follow up of neck pain and back pain. The injured worker reported persistent neck pain with some swelling in her neck. The injured worker has tried heat and ice therapy for her neck. The injured worker has also tried Ibuprofen without relief. The injured worker reported some improvement in insomnia with use of Restoril. Pain level was 5-7 out of 10 on a visual analog scale (VAS) with medications. Objective findings (07-07-2015 to 08-06-2015) revealed 45 degree forward flexion, 20 degrees of extension and 45 degrees of lateral bending bilaterally in the cervical spine. Physical exam also revealed palpable paraspinal and trapezius spasm at C4-7, and positive Spurling's maneuver for reproduction of radicular symptoms bilaterally in the third, fourth and fifth rays. The injured worker had palpable paraspinal spasm of the thoracic spine and lumbar spine, positive straight leg raises on the right with reproduction of radicular symptoms in the lateral aspect of the calf and dorsal lateral foot. Left shoulder exam revealed positive crossed impingement sign. Treatment has included diagnostic studies, prescribed medications, and periodic follow up visits. The treatment plan included medication management. The injured worker is permanent and stationary. The treating

physician prescribed services for transcutaneous electrical nerve stimulation (TENS) unit. The utilization review dated 08-20-2015, non-certified the request for transcutaneous electrical nerve stimulation (TENS) unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines do not recommend TENS as a primary treatment modality, but support consideration of a one-month home-based TENS trial used as an adjunct to a program of evidence-based functional restoration. Furthermore, criteria for the use of TENS includes pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, and a documented one-month trial period stating how often the unit was used, as well as outcomes in terms of pain relief and function. The documentation submitted for review did not indicate that a one month trial was completed. As such, medical necessity cannot be affirmed.