

<b>Case Number:</b>	CM15-0187319		
<b>Date Assigned:</b>	09/29/2015	<b>Date of Injury:</b>	05/12/2014
<b>Decision Date:</b>	11/10/2015	<b>UR Denial Date:</b>	08/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2015

### 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: Utah, Arkansas  
 Certification(s)/Specialty: Family Practice, Sports 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 54 year old female, who sustained an industrial injury on 5-12-14. The injured worker has complaints of achy headache radiating to cervical spine with a pain level of 7 out of 10; achy neck pain and stiffness radiating to bilateral shoulders with a pain level 8 out of 10 and a constant moderate dull upper and mid back pain radiating to lumbar spine with a pain level 7 out of 10. Cervical spine extension; left lateral bending; right lateral bending; left rotation range of motion is decreased. Thoracic spine flexion; left rotation and right rotation range of motion is decreased. Lumbar spine flexion; extension; left lateral bending and right lateral bending range of motion are decreased. The diagnoses have included displacement of cervical intervertebral disc without myelopathy. Treatment to date has included naproxen; pantoprazole and cyclobenzaprine. The original utilization review (8-25-15) non-certified the request for supplies for electrical stimulation unit, cervical, lumbar 5 month supply and acupuncture 2 times a week for 6 weeks, cervical spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Supplies for electrical stimulation unit, cervical, lumbar 5 month supply: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for TENS unit supplies. MTUS guidelines state the following: Not recommended as a primary treatment modality. While TENS may reflect the long standing accepted standard of care within many medical communities, the results of studies are inconclusive, the published trials do not provide parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Several studies have found evidence lacking concerning effectiveness. A one-month trial may be considered for condition of neuropathic pain and CRPS, phantom limb, multiple sclerosis and for the management of spasticity in a spinal cord injury. It is unclear if the patient underwent the 1 month trial period. There is also lack of documentation for objective and functional improvement. According to the clinical documentation provided and current MTUS guidelines; A TENS unit Supplies is not medically necessary to the patient at this time.

**Acupuncture 2 times a week for 6 weeks, cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Acupuncture. MTUS guidelines state the following: "Acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. MTUS guidelines state the following: initial trial of 3-6 visits over 3 weeks. Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. The patient has undergone 12 previous sessions of acupuncture. The request exceeds the recommended amount of Acupuncture recommended. There is also lack of documentation for functional improvement with the previous sessions. According to the clinical documentation provided and current MTUS guidelines; additional sessions of Acupuncture, as requested above, is not medically necessary to the patient at this time.