

<b>Case Number:</b>	CM15-0190454		
<b>Date Assigned:</b>	10/29/2015	<b>Date of Injury:</b>	09/24/2014
<b>Decision Date:</b>	12/11/2015	<b>UR Denial Date:</b>	09/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/28/2015

### 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: Physical Medicine & Rehabilitation

### 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 55 year old male, who sustained an industrial injury on 9-24-14. The injured worker has complaints of neck, upper and lower back and right knee pain the documentation noted that the neck had mild post, tenderness. The back had mild upper and lower tenderness and the right knee had mild tenderness. Cervical spine magnetic resonance imaging (MRI) on 4-29-15 revealed mild degenerative changes of the cervical intervertebral discs and facets causing mild central canal stenosis from C3-C4 to C5-C6 and moderate bilateral C3-C4 right C4-C5 and bilateral C5-C6 neural foraminal narrowing; there is a mild annular disc bulge at C6-C7 and at C7-T1 with bilateral neural foraminal narrowing at both levels. The diagnoses have included sprain of neck; sprain of thoracic and lumbar sprain and strain. Treatment to date has included 20 chiropractic visits for his neck and back up until 7-27-15; physical therapy; transcutaneous electrical nerve stimulation unit and medications. The original utilization review (9-14-15) non-certified the request for one therapeutic ultrasound and one transcutaneous electrical nerve stimulation unit. Several documents within the submitted medical records are difficult to decipher.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One therapeutic ultrasound:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic Chapter, under Ultrasound.

**Decision rationale:** The patient was injured on 09/24/14 and presents with pain in his neck, upper back, lower back, and right knee. The request is for one therapeutic ultrasound. The RFA is dated 08/30/15 and the patient's current work status is not provided. ODG Guidelines, Low Back - Lumbar & Thoracic Chapter, under Ultrasound, therapeutic Section states: "Not recommended based on the medical evidence, which shows that there is no proven efficacy in the treatment of acute low back symptoms. In this RCT ultrasound therapy was not efficacious in relieving chronic low back pain. (Licciardone, 2013) There is no high quality evidence to support the use of ultrasound for improving pain or quality of life in patients with non-specific chronic LBP." The patient is diagnosed with sprain of neck, sprain of thoracic spine, and lumbar spine sprain/strain. Treatment to date has included 20 chiropractic visits for his neck and back up, physical therapy, transcutaneous electrical nerve stimulation unit, and medications. The report with the request is not provided and the reason for the request is not provided either. In this case, the patient continues to have low back pain. In this case, the use of therapeutic Ultrasound Therapy for low back pain is not recommended by ODG guidelines. Given the lack of guideline support, the request IS NOT medically necessary.

**One TENS unit:** 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:** The patient was injured on 09/24/14 and presents with pain in his neck, upper back, lower back, and right knee. The request is for ONE TENS UNIT. The RFA is dated 08/30/15 and the patient's current work status is not provided. The patient has had prior use of the TENS unit. MTUS Guidelines, Transcutaneous Electrotherapy section, page 116 states that TENS unit have not proven efficacy in treating chronic pain and is not recommend as a primary treatment modality, but a 1-month home-based trial may be considered for a specific diagnosis of neuropathy, CRPS, spasticity, a phantom limb pain, and multiple sclerosis. When a TENS unit is indicated, a 30-day home trial is recommended, and with the documentation of functional improvement, additional usage maybe indicated. The patient is diagnosed with sprain of neck, sprain of thoracic spine, and lumbar spine sprain/strain. Treatment to date has included 20 chiropractic visits for his neck and back up, physical therapy, transcutaneous electrical nerve stimulation unit, and medications. The report with the request is not provided and the reason for the request is not provided either. Although the patient has had prior use of the TENS unit, there is no evidence of a one month trial as indicated by MTUS guidelines. There is no discussion

provided regarding how the prior TENS use impacted the patient's pain and function. Therefore, the requested TENS unit IS NOT medically necessary.