

Case Number:	CM15-0207194		
Date Assigned:	10/26/2015	Date of Injury:	06/15/2011
Decision Date:	12/08/2015	UR Denial Date:	09/21/2015
Priority:	Standard	Application Received:	10/21/2015

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, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

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 52 year old female, who sustained an industrial injury on 6-15-2011. The medical records indicate that the injured worker is undergoing treatment for status post anterior cervical discectomy and fusion at C5-C6 and C6-C7 (1-9-2012). According to the progress report dated 8-18-2015, the injured worker presented with complaints of severe pain in the cervical spine with radiation into the upper back, bilateral shoulders, and posterior aspect of head, associated with numbness, tingling, blurred vision, and dizziness. The level of pain was not rated. The physical examination of the cervical spine reveals tenderness and restricted range of motion. The current medications are not specified. Previous diagnostic studies include CT scan of the cervical spine. Treatments to date include medication management, trigger point injections, and surgical intervention. Work status is not indicated. The treatment plan included anterior cervical discectomy and fusion at C5, C6, and C7 and associated services. The original utilization review (9-21-2015) had non-certified a request for TENS unit and cryotherapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: 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: According to the California MTUS Chronic Pain Medical Treatment Guideline regarding TENS, pages 113-114, chronic pain (transcutaneous electrical nerve stimulation), not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for neuropathic pain and CRPS II and for CRPS I (with basically no literature to support use). Criteria for the use of TENS: Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. There is evidence that other appropriate pain modalities have been tried (including medication) and failed. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. In this case there is insufficient evidence of chronic neuropathic pain from the exam note of 8/18/15 to warrant a TENS unit. There also is no evidence of an evidence based functional restoration plan. Therefore, the request is not medically necessary.

Associated surgical service: Cryotherapy: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back / continuous flow cryotherapy.

Decision rationale: CA MTUS/ACOEM is silent on the issue of continuous flow cryotherapy. According to the ODG Neck and Upper back / continuous flow cryotherapy, it is not recommended in the neck. Local application of cold packs is recommended by the ODG Neck and Upper Back section. Therefore, the request is not medically necessary for the requested cold therapy vascultherm post C5-7 ACDF.