

<b>Case Number:</b>	CM15-0028398		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	04/04/2013
<b>Decision Date:</b>	04/06/2015	<b>UR Denial Date:</b>	01/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/15/2015

### 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: Preventive Medicine, Occupational 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:

This 37 year old female sustained an industrial injury on 4/4/13, with subs ongoing low back and right wrist pain. X-rays of bilateral shoulders, elbows, wrists, hands and lumbar spine were normal. Magnetic resonance imaging lumbar spine (3/29/14) was unremarkable. Electromyography/nerve conduction velocity test bilateral upper extremity (9/12/14) showed mild borderline right median neuropathy and mild bilateral ulnar neuropathy across the elbows. In a PR-2 dated 12/5/15, the injured worker complained of pain to the cervical spine, lumbar spine, bilateral shoulders and right wrist, 5-8/10 on the visual analog scale with radiation to bilateral upper and lower extremities associated with numbness and tingling. Physical exam was remarkable for painful and restricted range of motion to the cervical spine, lumbar spine and bilateral shoulders. Current diagnoses included cervical pain, lumbago, lumbar sprain, right shoulder injury, left shoulder pain and right wrist pain. The treatment plan included continuing medications (Protonix, Cyclobenzaprine, Gabapentin and Norco) and x-ray of the right shoulder. On 1/16/15, Utilization Review noncertified a request for 2 Leadwires, 5 months rental of multi-stimulator unit with installation, 1 adaptor and 40 Pairs of electrodes (8 pairs per month) noting lack of documentation indicating failure of conservative treatment modalities and citing CA MTUS Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**2 Leadwires:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**5 months rental of multi-stimulator unit with installation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 & 9792.26, Pages 118-120.

**Decision rationale:** Multiple stimulation unit are not recommended by the MTUS. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue, shoulder pain, cervical neck pain and knee pain. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. 5 months rental of multi-stimulator unit with installation is not medically necessary.

**1 Adaptor:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**40 Pairs of electrodes (8 pairs per month):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.