

<b>Case Number:</b>	CM15-0030345		
<b>Date Assigned:</b>	02/24/2015	<b>Date of Injury:</b>	03/05/2013
<b>Decision Date:</b>	04/02/2015	<b>UR Denial Date:</b>	01/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2015

### 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: Indiana

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:

The injured worker is a 49 year old female, who sustained an industrial injury on 3/5/13. She has reported neck and back injury. The diagnoses have included cervical sprain/strain, lumbar spine sprain/strain, mid back sprain/strain and right shoulder sprain/strain. Treatment to date has included oral medications and activity restrictions. X-ray of cervical spine revealed loss of lordosis, narrowing C5-6, C6-7 and limited range of motion; X-ray of the thoracic spine revealed upper thoracic kyphosis with wedging T6; x-ray of lumbar spine revealed scoliosis, narrowing of L5-S1 and limited range of motion and X-ray of right shoulder revealed calcific tendinitis. Currently, the injured worker complains of pain in neck with radicular symptoms to right and left arm, aggravated with lifting and pain in lower back with radicular symptoms to right and left leg aggravated with prolong sitting, standing and walking. On 12/16/14 limited range of motion of cervical spine and lumbar spine and right shoulder with tenderness over the greater tuberosity of right humerus; tightness and spasm in lumbar paraspinal musculature bilaterally and tightness and spasm in the trapezius, sternocleidomastoid and straps muscle bilaterally. On 1/26/15 Utilization Review non-certified interferential unit, noting the lack of documentation to support she has failed conservative therapy. The MTUS, ACOEM Guidelines, was cited. On 2/2/15, the injured worker submitted an application for IMR for review of interferential unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**IF Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 114-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, TENS chronic pain (transcutaneous electrical nerve stimulation).

**Decision rationale:** MTUS states regarding IF or TENS unit, "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 the conditions described below." For pain, MTUS and ODG recommend TENS (with caveats) for neuropathic pain, phantom limb pain and CRPSII, spasticity, and multiple sclerosis. The medical records do not indicate any of the previous conditions. ODG further outlines recommendations for specific body parts: Low back: Not recommended as an isolated intervention. Knee: Recommended as an option for osteoarthritis as adjunct treatment to a therapeutic exercise program. Neck: Not recommended as a primary treatment modality for use in whiplash-associated disorders, acute mechanical neck disease or chronic neck disorders with radicular findings. Ankle and foot: Not recommended. Elbow: Not recommended. Forearm, Wrist and Hand: Not recommended. Shoulder: Recommended for post-stroke rehabilitation. Medical records do not indicate conditions of the low back, knee, neck, ankle, elbow, or shoulders that meet guidelines. Of note, medical records do not indicate knee osteoarthritis. ODG further details criteria for the use of IF or TENS for Chronic intractable pain (for the conditions noted above): (1) Documentation of pain of at least three months duration (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed (3) 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 (4) Other ongoing pain treatment should also be documented during the trial period including medication usage (5) A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted (6) After a successful 1-month trial, continued TENS treatment may be recommended if the physician documents that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. At this point purchase would be preferred over rental. (7) Use for acute pain (less than three months duration) other than post-operative pain is not recommended. (8) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. The medical records do not satisfy the several criteria for selection specifically, lack of documented 1-month trial, lack of documented short-long term treatment goals with IR or TENS unit, and unit use for acute (less than three months) pain. As such, the request for 1 IF Unit is not medically necessary.