

<b>Case Number:</b>	CM15-0030425		
<b>Date Assigned:</b>	02/24/2015	<b>Date of Injury:</b>	06/14/2012
<b>Decision Date:</b>	04/22/2015	<b>UR Denial Date:</b>	01/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2015

### 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:

The injured worker is a 39 year old female who sustained an industrial injury on 06/14/2012. She reported that while lifting a case of product she heard a pop in her neck that led to stiffness and pain that radiated down her bilateral arms with numbness and weakness. The injured worker was diagnosed with status post cervical five through seven anterior cervical discectomy and fusion, cervicgia, and possible residual cervical radiculopathy. Treatment to date has included medication regimen, above listed procedure, x-rays of the cervical spine, electromyogram, magnetic resonance imaging of the cervical spine, physical therapy, medial branch blocks on the right side, and trigger point injections. In a progress note dated 12/17/2014 the treating provider reports complaints of aching neck pain that is rated an eight out of ten, difficulty turning the head secondary to pain, mild tenderness throughout the cervical spine, and severe tenderness to palpation of the right cervical paraspinal, sternocleidomastoid, and upper trapezius muscle. The treating physician requested a trial use of a transcutaneous electrical nerve stimulation unit with supplies with the treating physician noting that the injured worker was treated with a transcutaneous electrical nerve stimulation unit during physical therapy and noted it was helpful.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Skin Preps, Lead Wires, Replacement Batteries, Quantity Unspecified QTY:1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management section Page(s): 7.

**Decision rationale:** The MTUS Guidelines explain that the treatment of pain requires a thorough understanding of the mechanism underlying the pain as well as to identify comorbidities that might predict an adverse outcome. Consideration of comorbid conditions, side effects, cost, and efficacy of medication versus physical methods and provider and patient preferences should guide the physician's choice of recommendations. Choice of pharmacotherapy must be based on the type of pain to be treated and there may be more than one pain mechanism involved. The physician should tailor medications and dosages to the individual taking into consideration patient-specific variables such as comorbidities, other medications, and allergies. The physician should be knowledgeable regarding prescribing information and adjust the dosing to the individual patient. If the physician prescribes a medication for an indication not in the approved FDA labeling, he or she has the responsibility to be well informed about the medication and that its use is scientific and evidence-based. When effective, medications provide a degree of analgesia that permits the patients to engage in rehabilitation, improvement of activities of daily living, or return to work. This request is not for a medication, but for supplies to support the use of a TENS unit. This request was originally accompanied with a request for trial use of TENS unit and supplies to support use during the trial period. Utilization review recommended approval of all items to support this trial period, but this request is in addition to the items necessary to support the trial use of the TENS unit. Medical necessity for additional supplies could not be established at this time because the trial period and follow up assessment for treatment efficacy had not taken place. The request for Skin Preps, Lead Wires, Replacement Batteries, Quantity Unspecified QTY:1 is determined to not be medically necessary.