

Case Number:	CM15-0040831		
Date Assigned:	03/11/2015	Date of Injury:	12/22/2010
Decision Date:	04/22/2015	UR Denial Date:	02/02/2015
Priority:	Standard	Application Received:	03/04/2015

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:

This 31 year old female sustained a work related injury on 12/22/2010. According to a progress report dated 12/08/2014, the injured worker was having a severe exacerbation of her neck pain that radiated to her upper extremities. Objective findings included palpable spasms over the cervical musculature. Range of motion was significantly decreased with flexion of 20 degrees, back extension 10 degrees, rotation to the right 45 degrees and to the left was 30 degrees. There was decreased sensation of the left side of the face with ringing in the ears. Diagnostic impressions included cervical sprain/strain, cervical facet syndrome and sleep disturbance. The injured worker received a steroid injection to the cervical spine and experienced improvement in her pain but continued with severe pain. The provider noted that her condition was getting progressively worse. She was advised to follow works restrictions to avoid further injury. She was not able to take time off of work because of financial constraints. On 01/14/2015, a prescription was written for a TENS unit and supplies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Leadwire: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Interferential Current Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: The patient presents with severe unrated neck pain which radiates into the bilateral upper extremities. The patient's date of injury is 12/22/10. Patient is status post cervical ESI at a date and level unspecified. The request is for LEADWIRE. The RFA was not provided. Physical examination dated 12/08/14 reveals tenderness to palpation and spasms of the cervical paraspinal muscles, decreased range of motion especially on flexion, decreased sensation to the left side of the face, and ringing in the ears. The patient's current medication regimen was not provided. Diagnostic imaging was not included. Patient is currently working. Regarding Interferential Current Stimulation, the MTUS guidelines, pages 118 - 120, states: "Not recommended as an isolated intervention. 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. These devices are recommended in cases where 1. Pain is ineffectively controlled due to diminished effectiveness of medications; or 2. Pain is ineffectively controlled with medications due to side effects; or 3. History of substance abuse; or 4. Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or 5. Unresponsive to conservative measures." As a conservative therapy for pain reduction, ICS/TENS units, and the associated leads, offer a reasonable avenue of pain control in patients for whom there is a proven efficacy. Memorandum dated 12/08/14 recommends purchases of an Orthostim device and attributes a 33 percent reduction in pain following use. However, there is no explanation as to what "leadwires" are. Typically, pads and wires are part of the unit which was already authorized for purchase. The treater does not explain why additional add on items are needed for this particular unit. The request IS NOT medically necessary.

Adhesive remover towel mint: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Interferential Current Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: The patient presents with severe unrated neck pain which radiates into the bilateral upper extremities. The patient's date of injury is 12/22/10. Patient is status post cervical ESI at a date and level unspecified. The request is for ADHESIVE REMOVER TOWEL MINT. The RFA was not provided. Physical examination dated 12/08/14 reveals tenderness to palpation and spasms of the cervical paraspinal muscles, decreased range of motion especially on flexion, decreased sensation to the left side of the face, and ringing in the ears. The patient's current medication regimen was not provided. Diagnostic imaging was not included. Patient is currently

working. Regarding Interferential Current Stimulation, the MTUS guidelines, pages 118 - 120, states: "Not recommended as an isolated intervention. 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. These devices are recommended in cases where 1. Pain is ineffectively controlled due to diminished effectiveness of medications; or 2. Pain is ineffectively controlled with medications due to side effects; or 3. History of substance abuse; or 4. Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or 5. Unresponsive to conservative measures." In this case this patient has been authorized the purchase of an Orthostim unit, there is no explanation regarding the need for "adhesive remover". Pads used for electrical units are typically easy to remove and used for multiple treatments before they are replaced. The requested "adhesive remover" sounds excessive and unnecessary and the treater does not explain the need for additional cost. The request IS NOT medically necessary.