MAXIMUS Federal Services

Case Number:	CM15-0069722		
Date Assigned:	04/27/2015	Date of Injury:	01/11/2014
Decision Date:	09/01/2015	UR Denial Date:	03/24/2015
Priority:	Standard	Application Received:	04/13/2015

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: New York
Certification(s)/Specialty: Internal 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 48 year old female who sustained an industrial injury on 1/11/14. She had initial complaints of neck, mid and low back injuries after getting hit with boxes and hearing a cracking sound in her back with sharp pain working as a laborer. The diagnoses have included lumbar strain/sprain, cervical spine strain/sprain, thoracic strain/sprain, disc displacement, radiculitis, Herniated Nucleus Pulposus (HNP), lumbar spine pain, Herniated Nucleus Pulposus (HNP), and lower extremity radiculitis. Treatment to date has included medications, diagnostics, Functional Capacity Evaluation (FCE), rest, physical therapy, pain management, and activity restrictions/modifications. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the thoracic pine, Magnetic Resonance Imaging (MRI) of the lumbar spine, and Magnetic Resonance Imaging (MRI) of the cervical spine. Currently, as per the physician progress note dated 2/13/15, the injured worker complains of neck, mid back and low back pain. The neck pain was associated with numbness and tingling in the bilateral upper extremities. The pain was unchanged from previous visit and rated 4-8/10 on pain scale. The low back pain is also associated with numbness and tingling in the bilateral lower extremities (BLE) and has an effect on her activities of daily living (ADL). She reports relief with medications, rest and activity restrictions. The physical exam revealed the cervical spine had lateral head tilt to the right, tenderness, trigger points, decreased range of motion, positive orthopedic tests, and diminished sensation. The thoracic spine exam revealed tenderness decreased range of motion, and positive Kemp's test. The lumbar spine exam revealed pain with heel toe walking, decreased ability to squat due to pain in the low back, muscle guarding was noted, tenderness bilaterally,

decreased range of motion, positive straight leg raise bilaterally and decreased sensation was noted. There was no previous therapy sessions noted. There was no urine drug screen noted. Work status was return to work with modified duties/restrictions. The physician requested treatments included Deprizine, unspecified quantity or dosage, Dicopanol, Synapryn, Tabradol (Cyclobenzaprine), Capsaicin, Flurbiprofen, Fanatrex (Gabapentin), UA toxicological evaluation, X-rays of the cervical, thoracic and lumbar spine, electromyography (EMG) nerve conduction velocity studies (NCV) of the bilateral upper extremities, electromyography (EMG) nerve conduction velocity studies (NCV) of the bilateral lower extremities, Functional capacity evaluation, physical therapy for the cervical, thoracic and lumbar spine, three times a week for six weeks, acupuncture for the cervical, thoracic, and lumbar spine, three times a week for six weeks, localized intense neurostimulation therapy for the cervical, thoracic and lumbar spine, once a week for six to nine weeks, six shock wave therapy treatments for the thoracic and lumbar spine, transcutaneous electrical nerve stimulation (TENS) unit with supplies for home use, Hot/Cold unit, Terocin patches, magnetic resonance imaging (MRI) of the cervical, thoracic and lumbar spine and menthol.

IMR ISSUES, DECISIONS AND RATIONALES

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

Deprizine, unspecified quantity or dosage: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Medical food.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): s 68-69.

Decision rationale: The prescription for Deprizine is evaluated in light of the MTUS recommendations. Deprizine is ranitidine in an oral suspension. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age greater than 65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and or anticoagulants or high-dose multiple NSAIDs. If Ranitidine is prescribed as cotherapy with an NSAID, ranitidine is not the best drug. Cotherapy with an NSAID is not indicated in patients other than those at high risk. No reports describe the specific risk factors present in this case. Medical necessity of the requested item has not been established.

Dicopanol: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Medical food.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia Treatment.

Decision rationale: Official Disability Guidelines (ODG) state Over-the-counter medications; sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Side effects include urinary retention, blurred vision, orthostatic hypotension, dizziness, palpitations, increased liver enzymes, drowsiness, dizziness, grogginess and tiredness. The treating physician has stated that Dicopanol is diphenhydramine and other proprietary ingredients. Medical necessity cannot be determined for unspecified compounds, and unpublished ingredients cannot be assumed to be safe or effective. Dicopanol is not medically necessary on this basis alone. In addition, Dicopanol is stated to be for insomnia. No physician reports describe the specific criteria for a sleep disorder. Treatment of a sleep disorder, including prescribing hypnotics, should not be initiated without a careful diagnosis. There is no evidence of that in this case. Official Disability Guidelines states that antihistamines are not indicated for long term use as tolerance develops quickly, and that there are many, significant side effects. MTUS states Medications are to be given individually, one at a time, with assessment of specific benefit for each medication. Provision of multiple medications simultaneously is not recommended. Dicopanol is not medically necessary based on lack of a sufficient analysis of the patient's condition, and lack of information provided about the ingredients.

Synapryn: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Medical food.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Opioids, Topical Medications Page(s): s 50, 60, 77-80, and 111-113.

Decision rationale: Official Disability Guidelines (ODG) state Over-the-counter medications; sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Side effects include urinary retention, blurred vision, orthostatic hypotension, dizziness, palpitations, increased liver enzymes, drowsiness, dizziness, grogginess and tiredness. The treating physician has stated that Dicopanol is diphenhydramine and other proprietary ingredients. Medical necessity cannot be determined for unspecified compounds, and unpublished ingredients cannot be assumed to be safe or effective. Dicopanol is not medically necessary on this basis alone. In addition, Dicopanol is stated to be for insomnia. No physician reports describe the specific criteria for a sleep disorder. Treatment of a sleep disorder, including prescribing hypnotics, should not be initiated without a careful diagnosis. There is no evidence of that in this case. Official Disability Guidelines states that antihistamines are not indicated for long term use as tolerance develops quickly, and that there are many, significant side effects. MTUS states Medications are to be given individually, one at a time, with assessment of specific benefit for each medication. Provision of multiple medications simultaneously is not recommended. Dicopanol is not medically necessary based on

lack of a sufficient analysis of the patient's condition, and lack of information provided about the ingredients.

Tabradol (Cyclobenzaprine): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): s 63-65. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Muscle relaxants.

Decision rationale: Tabradol is Cyclobenzaprine in an oral suspension. According to the reviewed literature, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. In addition, this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. In this case, the available records are not clear if the injured worker has shown a documented benefit or any functional improvement from prior Cyclobenzaprine use. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

Capsaicin: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): s 111 to 113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, Capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least one non-recommended drug (or drug class) is not recommended for use. The CA MTUS states that Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. In this injured worker the medical necessity for the requested topical cream has not been established. Therefore, as per guidelines stated above, the requested topical cream is not medically necessary.

Flurbiprofen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): s 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, Capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least one non-recommended drug (or drug class) is not recommended for use. Flurbiprofen is used as a topical NSAID. It has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either, not afterward, or with diminishing effect over another two-week period. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). Dose, frequency and quantity have not been specified. In this injured worker, the medical necessity for the requested topical cream has not been established. Therefore, as per guidelines stated above, the requested topical cream is not medically necessary.

Fanatrex (Gabapentin): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): s 16-20, and 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Anti-epilepsy drugs (AEDs) for pain.

Decision rationale: Fanatrex is stated to be a formulation of gabapentin. According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. The records documented that this injured worker has neuropathic pain related to her chronic low back condition. There are no clear physician reports which adequately address the specific symptomatic and functional benefit from the AEDs used to date. In the submitted medical records, there is no mention by the treating provider about preferring oral solution. Medical necessity of Fanatrex (Gabapentin) has not been established. The requested medication is not medically necessary.

UA toxicological evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Urine Drug Testing (UDT).

Decision rationale: UDT is recommended at the onset of treatment of a new patient who is already receiving a controlled substance or when chronic opioid management is considered. Urine drug testing is not generally recommended in acute treatment settings (i.e. when opioids are required for nociceptive pain), (2) In cases in which the patient asks for a specific drug. This is particularly the case if this drug has high abuse potential, the patient refuses other drug treatment and or changes in scheduled drugs, or refuses generic drug substitution, (3) If the patient has a positive or "at risk" addiction screen on evaluation. This may also include evidence of a history of comorbid psychiatric disorder such as depression, anxiety, bipolar disorder, and or personality disorder. See Opioids, screening tests for risk of addiction & misuse, (4) If aberrant behavior or misuse is suspected and or detected. Review of medical records does not indicate substance abuse, noncompliance, or aberrant behavior. The treating provider does not provide any documentation about the need for Urine Toxicology. Guidelines are not met, therefore, the request for Urine Toxicology Screen is not medically necessary.

X-rays of the cervical, thoracic and lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Low Back Chapter, Radiography (X-rays).

Decision rationale: As per ODG, criteria for imaging, Plain X-rays are: Cervical spine trauma, unconscious-Cervical spine trauma, impaired sensorium (including alcohol and/or drugs). Cervical spine trauma, multiple trauma and/or impaired sensorium, Cervical spine trauma (a serious bodily injury), neck pain, no neurological deficit, Cervical spine trauma, alert, cervical tenderness, paresthesias in hands or feet. Cervical spine trauma, alert, cervical tenderness - Chronic neck pain (= after 3 months conservative treatment), patient younger than 40, no history of trauma, first study, Chronic neck pain, patient younger than 40, history of remote trauma, first study, Chronic neck pain, patient older than 40, no history of trauma, first study. Chronic neck pain, patient older than 40, history of remote trauma, first study, Chronic neck pain, patients of any age, history of previous malignancy, first study, Chronic neck pain, patients of any age, history of previous remote neck surgery, first study, Post-surgery: evaluate status of fusion. MTUS/ACOEM Guidelines state X-ray of Lumbar spine is not recommended in in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted has for at least six weeks. As per ODG criteria for imaging, Plain X-rays are: Lumbar spine trauma (a serious bodily injury): pain, tenderness. Lumbar spine trauma: trauma, neurological deficit. Lumbar spine trauma: seat belt (chance) fracture - Uncomplicated low back pain, trauma, steroids, osteoporosis, over 70 - Uncomplicated low back pain, suspicion of cancer, infection - Myelopathy (neurological deficit related to the spinal cord), traumatic - Myelopathy, painful - Myelopathy, sudden onset - Myelopathy, infectious disease patient. Myelopathy,

oncology patient - Post-surgery: evaluate status of fusion. From the submitted Medical Records it is unclear how the X-ray will change the management. The injured worker has no progressive neurological deficits, no new red flags, and no recent acute injury. Without such evidence and based on guidelines cited, the request for X-rays of the cervical, thoracic, and lumbar spine is not medically necessary and appropriate.

EMG/NCV of the bilateral upper extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): s 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Electrodiagnostic testing (EMG/NCS).

Decision rationale: The California MTUS/ACOEM Guidelines state, "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." The ODG regarding nerve conduction studies (NCS) states, "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." The objective findings on examination did not include evidence of neurologic dysfunction such as sensory, reflex, or motor system change. There were no symptoms or findings that define evidence of a peripheral neuropathy. There was insufficient information provided by the attending health care provider to establish the medical necessity or rationale for the requested electrodiagnostic studies. The request for an EMG/NCV of the bilateral upper extremities is not medically necessary and appropriate.

EMG/NCV of the bilateral lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic testing (EMG/NCS).

Decision rationale: The California MTUS/ACOEM Guidelines state, "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." The ODG regarding nerve conduction studies (NCS) states, "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's

are not necessary if radiculopathy is already clinically obvious." The objective findings on examination did not include evidence of neurologic dysfunction such as sensory, reflex, or motor system change. There were no symptoms or findings that define evidence of a peripheral neuropathy. There was insufficient information provided by the attending health care provider to establish the medical necessity or rationale for the requested electrodiagnostic studies. The request for an EMG/NCV of the bilateral lower extremities is not medically necessary and appropriate.

Functional capacity evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): s 89-90. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Work conditioning, Work hardening.

Decision rationale: A number of functional assessment tools are available, including functional capacity exams and videotapes. Most assess general functioning, but modifications to test work-related functioning are under development or can be created by the clinician. ODG states valid Functional Capacity Evaluation (FCE) should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs. Within the medical information available for review, the injured worker has chronic pain and there is no indication the injured worker is close or at maximum-medical-improvement (MMI). There is no documentation of prior unsuccessful return-to-work (RTW) attempts. Medical records lack information about job description, physical demand level and specific work-related tasks. Also records do not document injured worker's return to work goals. The medical necessity of the Requested Treatment: Functional capacity evaluation has not been established and is not medically necessary.

Physical therapy for the cervical, thoracic and lumbar spine, three times a week for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): s 98-99.

Decision rationale: The prescription for Physical Therapy is evaluated in light of the MTUS recommendations for Physical Therapy. MTUS recommends 1) Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries.

They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 2) Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The records are not clear if the injured worker had prior physical therapy, and what was the objective outcome. Also there is no mention of any significant change of symptoms or clinical findings, or acute flare up to support PT. The request for physical therapy is not medically necessary and appropriate.

Acupuncture for the cervical, thoracic, and lumbar spine, three times a week for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: This prescription for acupuncture is evaluated in light of the MTUS recommendations for acupuncture. The MTUS recommends an initial trial of 3-6 visits of acupuncture. Per the MTUS, "Acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery." Medical necessity for any further acupuncture is considered in light of functional improvement. The records are not clear if the injured worker had prior acupuncture therapy, and what was the objective outcome. There was no discussion by the treating physician regarding a decrease or intolerance to pain medications. Also 18 visits of acupuncture exceed the MTUS recommendation. Given the MTUS recommendations for use of acupuncture, the prescription for the cervical, thoracic, and lumbar spine, three times a week for six weeks is not medically necessary.

Localized intense neurostimulation therapy for the cervical, thoracic and lumbar spine, once a week for six to nine weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Hyperstimulation analgesia.

Decision rationale: As per Official Disability Guidelines (ODG), trigger point impedance imaging localized intense neuro-stimulation therapy is not recommended until there are higher

quality studies. Initial results are promising, but only from two low quality studies sponsored by the manufacturer ([redacted]., [redacted]). Localized manual high-intensity neurostimulation devices are applied to small surface areas to stimulate peripheral nerve endings (A fibers), thus causing the release of endogenous endorphins. This procedure, usually described as hyperstimulation analgesia, has been investigated in several controlled studies. However, such treatments are time consuming and cumbersome, and require previous knowledge of the localization of peripheral nerve endings responsible for LBP or manual impedance mapping of the back, and these limitations prevent their extensive utilization. In this case, there is no compelling evidence presented by the treating provider that indicates the need for this therapy in this injured worker. Based on the currently available information in the submitted Medical Records of this injured worker, and per review of guidelines, the medical necessity for localized intense neuro-stimulation therapy has not been established.