

Case Number:	CM14-0182597		
Date Assigned:	11/07/2014	Date of Injury:	12/16/2013
Decision Date:	12/17/2014	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	11/03/2014

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. The expert reviewer is Board Certified in Physical Medicine & rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 47-year-old male with a date of injury of 12/16/2013. The listed diagnoses are: 1. Discogenic cervical condition with facet inflammation and headaches. 2. Discogenic thoracic condition with facet inflammation. 3. Discogenic lumbar condition with facet inflammation with bilateral radiculopathy with numbness and tingling. 4. Element of stress, depression, headaches, anxiety, sleep dysfunction, fatigue, and constipation. 5. Sexual dysfunction related to chronic pain. According to progress report 06/24/2014, the patient presents with headaches, neck pain, back pain, intermittent shoulder pain, depression, anxiety, and sleep dysfunction. Physical examination of the neck and upper extremity revealed decreased range of motion in the neck, shoulders and elbows. Sensation is intact throughout the bilateral upper extremities. The patient has full strength to resisted function. The patient had tenderness along the cervical paraspinal muscles, trapezius, and shoulder girdle. Evaluation of the lower back revealed slightly antalgic gait, and the patient is able to stand on toes and heels. There is decreased range of motion, and straight leg raise was positive on the right at 60 degrees and negative on the left. Treater recommends back brace, cervical traction, cervical pillow, hot-and-cold wrap, TENS unit, and medications. Utilization review denied the request on 10/22/2014. Treatment reports from 01/23/2014 through 09/22/2014 were provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transcutaneous electrical nerve stimulation (TENS) unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 116.

Decision rationale: This patient presents with upper and lower extremity complaints, headaches, sleep issues, and depression. Treater requests a transcutaneous electrical nerve stimulation (TEN) unit. Per MTUS Guidelines page 116, TENS unit have not proven efficacy in treating chronic pain and is not recommended as a primary treatment modality, but a 1 month home-based trial may be considered for specific diagnosis of neuropathy, CRPS, spasticity, phantom limb pain, and multiple scoliosis. When a TENS unit is indicated, a 30-home trial is recommended and with documentation of functional improvement, additional usage may be indicated. In this case, the treater is requesting a TENS unit, but does not document a successful home one-month trial. The request is not medically necessary.

Polar Care 21 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment. Decision based on Non-MTUS Citation ODG, Neck and Upper Back

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) chapter, Continuous-flow cryotherapy

Decision rationale: This patient presents with upper and lower extremity complaints, headaches, sleep issues, and depression. Treater requests a Polar Care 21-day rental. The MTUS and ACOEM guidelines do not discuss cold therapy units. Therefore, ODG Guidelines are referenced. ODG Guidelines has the following regarding continuous-flow cryotherapy: "Recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." ODG does not recommend continuous-flow cryotherapy for nonsurgical treatment. There is no indication of recent or projected surgery. Therefore, the request is not medically necessary.