

<b>Case Number:</b>	CM14-0092398		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	03/10/2008
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	05/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2014

### 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 Internal Medicine, has a subspecialty in Pulmonary Diseases 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 injured worker is a 62 year-old female who reported a work related injury on 03/10/2008 due to cumulative injuries. The injured worker's diagnoses consist of lumbar facet arthropathy, bilateral cubital tunnel syndrome, and bilateral carpal tunnel syndrome, and depression, neural foraminal narrowing from C4-5 and C5-6, and cervical radiculopathy. The injured worker has received chiropractic care which she received "benefit and pain control", and medication. An electromyography and nerve conduction test dated 12/15/2011 revealed severe bilateral carpal tunnel syndrome. A MRI of the cervical spine dated 06/16/2011 revealed a disc bulge at C3-4, C4-5, C5-6 and C7-T1. A MRI of the lumbar spine date 06/16/2011 revealed neural foraminal narrowing and degenerative spondylolisthesis. There is no surgical history provided for review. Upon examination on 02/17/2014 the injured worker complained of increased complaints of neck pain which radiated down the bilateral upper extremities which she rated as a 7/10 on a VAS pain scale. The injured worker also complained of lower back pain with numbness down the left lower extremity which was also rated as a 7/10. It was noted that the injured worker has no swelling or gross atrophy of the paracervical muscles and cervical lordosis is well maintained. Upon palpation of the cervical spine there was evidence of tenderness and spasms of the paracervical muscles. There was also tenderness over the base of the neck and skull. Tenderness was also noted to the trapezius musculature bilaterally. Sensory was noted to be intact in the bilateral upper and lower extremities to light touch and pinprick. There was also decreased range of motion. An orthopedic testing of the cervical spine revealed local pain. The treatment plan consisted of 12 sessions of chiropractic care two times a month for six months to the cervical and lumbar spine, switch Restoril for Zanaflex, start Protonix, and follow up in 5 to 6 months. The rationale for the request of retrospective care such as; 3 packets of electrodes #10, multi-

functional stimulator for 9 month rental, and conductive Gel #10 were not provided for review. The request for authorization form was not submitted for review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **3 packets of electrodes #10: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back (updated 04/14/14)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

**Decision rationale:** As a result of the primary procedure not being medically necessary, none of the associated services are medically necessary.

#### **Multi-functional stimulator for 9 month rental: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back (updated 04/14/14)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS, Page(s): 116.

**Decision rationale:** The request for multi-functional stimulator for 9 month rental is not medically necessary. According to the California MTUS the criteria for a TENS unit would include; documentation of pain of at least 3 months duration, evidence that other appropriate pain modalities have been tried including medication and failed, 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 and other ongoing pain treatment should also be documented during the trial period to include medication usage, a treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. Within the documentation submitted for review in regards to the request of a multi-functional stimulator there were no notes stating when the unit was started. Additionally, there were no signs and symptoms noted that would warrant the need for a stimulator. Furthermore, there was no documentation provided for the trial of the unit for a month with evidence of objective measures of improvement. The documentation would have to indicate improved positional tolerance, range of motion, and functional improvement in regards to daily activities. With the lack of documentation provided for review it is hard to conclude that a multi-functional stimulator was a medical necessity. As such, the request for multi-functional stimulator for 9 month rental is not medically necessary.

**Conductive Gel #10:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back (updated 04/14/14)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

**Decision rationale:** As a result of the primary procedure not being medically necessary, none of the associated services are medically necessary.