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| Case Number: | CM14-0167415 | | |
| Date Assigned: | 10/14/2014 | Date of Injury: | 07/15/2014 |
| Decision Date: | 01/06/2015 | UR Denial Date: | 10/06/2014 |
| Priority: | Standard | Application Received: | 10/10/2014 |

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 54-year-old woman who sustained a work-related injury on May 11, 2012. Subsequently, the patient developed chronic neck, back, wrists, and hands pain. Prior treatments had included: medications, Botox injections, acupuncture for the left hand, and chiropractic therapy for the neck, which included hot packs, massage, electrical stimulation, and adjustments (it provided moderate relief). The patient had several cortisone injections to the wrists and braces for the hands as well. According to a progress report dated September 30, 2014, the patient complained of constant neck pain, rated 8/10, with radiation to the bilateral shoulders and shoulder blades. The patient reported constant bilateral wrist and hand pain, rated 5/10 on the right and 6/10 on the left, with associated numbness with grasping. She also reported constant mid back pain, rated 5/10. In addition, she complained of constant low back pain, rated 7/10, with radiation to the bilateral lower extremities specifically to the buttocks. She still complained of persistent dizziness and periods of poor balance. She noted that her neck, mid back, and low back pain feels worse while her bilateral wrist and hand pain remained the same since her last visit. Examination of the cervical spine revealed a strongly positive cervical compression test. Spurling's maneuver was strongly positive bilaterally as well. Motor strength testing in the upper extremities revealed weakness in the triceps and wrist extensor muscle groups at 4/5. Motor strength was 5/5 in the biceps. Deltoid was 5/5 with some breakthrough pain. Deep tendon reflexes were also depressed in the bilateral brachioradialis and triceps. Hoffman sign was negative, clonus was absent and capillary refill was brisk. Examination of the bilateral wrists and hands revealed atrophy in the hands. There was weakness with wrist extension that was progressive. Examination of the lumbar spine revealed diffuse tenderness to palpation. There was sciatic tenderness. Straight leg raise test and tension signs were negative. Babinski's reflexes were down going. The patient was diagnosed with cervical spine sprain/strain, thoracic spine

sprain/strain, lumbar spine sprain/strain, bilateral upper and lower extremity radicular pain and paresthesias, bilateral wrist sprain/strain, bilateral De Quervain's tenosynovitis, hypertension, bilateral hearing loss, cervical radiculitis and radiculopathy with neck and upper extremity symptoms, and cervical stenosis at C5-6 and C6-7. The provider requested authorization for the followings.

IMR ISSUES, DECISIONS AND RATIONALES

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

■■■■■ stimulator purchase, plus 3 months supplies, and 2 conductive garments: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: According to MTUS guidelines, Interferential Current Stimulation (ICS) are 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodological issues. While not recommended as an isolated intervention, the patient selection criteria, if Interferential stimulation is to be used anyway, it is possibly appropriate for the following conditions pain is ineffectively controlled due to diminished effectiveness of medications; pain is ineffectively controlled with medications due to side effects; history of substance abuse; significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.) There is no clear evidence that the patient did not respond to conservative therapies, or have post op pain that limit his ability to perform physical therapy. There is no clear evidence that the neurostimulator will be used as a part of a rehabilitation program. In addition, there is limited evidence supporting the use of neuromuscular stimulator for chronic pain. Therefore, the decision for ■■■■■ stimulator purchase, plus 3 months supplies, and 2 conductive garments is not medically necessary.

TENS unit for joint stimulation with build in TENS feature, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous Electrical Nerve Stimulation Page(s): 97.

Decision rationale: According to MUTUS guidelines, TENS is not recommended as primary treatment modality, but a one month based trial may be considered, if used as an adjunct to a functional restoration program. There is no evidence that a functional restoration program is planned for this patient. Furthermore, there is no clear information about a positive one month trial of TENS. There is no recent documentation of recent flare of her pain. The provider should document how TENS will improve the functional status and the patient's pain condition. Therefore, this request is not medically necessary.

■■■■■ **FIR heating system:** Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

Decision rationale: Since the specialized heating unit is not medically necessary, this request is not medically necessary.

FIR heat pad, portable, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

Decision rationale: Since the specialized heating unit is not medically necessary, this request is not medically necessary.

■■■■■ **lumbar pneumatic brace, purchase:** Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: According to MTUS guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. A lumbar corset is recommended for prevention and not for treatment. Therefore, the request for ■■■■■ lumbar pneumatic brace is not medically necessary.