

<b>Case Number:</b>	CM15-0113533		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	03/13/2014
<b>Decision Date:</b>	07/20/2015	<b>UR Denial Date:</b>	05/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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: Arizona, California  
 Certification(s)/Specialty: Family Practice

### 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 54 year old female, who sustained an industrial injury on 3/13/14. The documentation noted under review of systems the injured worker has complaints of fatigue and light sensitivity. The injured worker has complains of muscle cramps, stiffness, back pain and muscle aches. She has complaints of headaches, poor balance, disturbances incoordination, falling down, visual disturbances and memory loss. The diagnoses have included postconcussion syndrome; myalgia/myositis; occipital neuralgia and cervicgia. Treatment to date has included occupational therapy cognitive function that demonstrated similar functional impairments; a speech therapy evaluation and was found to have memory and cognitive function deficits; klonopin; aleve and lidoderm patch. The request was for transcutaneous electrical nerve stimulation unit times one month trial quantity 1 and home traction unit for home use quantity 1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit x 1 month trial Qty: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 113-115.

**Decision rationale:** According to the MTUS guidelines, a TENS unit is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. It is recommended for the following diagnoses: CRPS, multiple sclerosis, spasticity due to spinal cord injury and neuropathic pain due to diabetes or herpes. In this case, the claimant did not have the above diagnoses. The length of use was not specified. The request for a TENS unit is not medically necessary.

**Home traction unit for home use Qty: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and upper back.

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

**Decision rationale:** According to the guidelines, Traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended. In this case, the claimant was already undergoing therapy and medications which provide more benefit. The request for traction with unspecified length of time is not medically necessary.