

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM15-0048468 |                              |            |
| <b>Date Assigned:</b> | 03/20/2015   | <b>Date of Injury:</b>       | 05/10/2014 |
| <b>Decision Date:</b> | 05/01/2015   | <b>UR Denial Date:</b>       | 02/16/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/13/2015 |

### 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 Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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:

This 62-year-old male sustained an industrial injury to the back and neck on 5/10/14. Previous treatment included magnetic resonance imaging, electromyography, physical therapy, epidural steroid injections, trigger point injections and medications. In a request for authorization dated 1/28/15, the injured worker complained of ongoing neck and low back pain. Physical exam was remarkable for cervical spine with tenderness to palpation in the cervical spine musculature, trapezius, medial scapular and subsequent-occipital region with multiple trigger points and taut bands, limited range of motion, intact upper extremity motor strength and lumbar spine with normal lumbar lordosis, tenderness to palpation to the lumbar spine paraspinal musculature and sciatic notch region with trigger points, taut bands, restricted range of motion, decreased sensation to bilateral lower extremities and positive bilateral straight leg raise. Current diagnoses included cervical spine sprain/strain with right upper extremity radiculopathy, lumbar spine sprain/strain with bilateral lower extremity radiculopathy and medication induced gastritis. The treatment plan included continuing medications (Anaprox, Prilosec, LidoPro), lumbar home rehabilitation kit for self-directed physiotherapy, hot and cold ice packs and a one month trial of home based transcutaneous electrical nerve stimulator unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interferential/transcutaneous electrical nerve stimulation IF/TENS combo unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation Page(s): 114.

**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. Therefore, the prescription of nterferential/transcutaneous electrical nerve stimulation IF/TENS combo unit is not medically necessary.

**Lumbar exercise kit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Medical Treatment Guidelines Exercise Page(s): 46-47.

**Decision rationale:** According to MTUS guidelines, an exercise program is recommended. "There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated. Such programs should emphasize education, independence, and the importance of an on-going exercise regime". There is no clear documentation for the need of home exercise program; the patient lumbar range of motion was relatively preserved and there is no documentation of disabling pain. In addition, the request does not address who will be monitoring the patient functional improvement. Therefore, the request for home exercise kit is not medically necessary.