

<b>Case Number:</b>	CM15-0078764		
<b>Date Assigned:</b>	04/29/2015	<b>Date of Injury:</b>	09/20/2010
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	04/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2015

### 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 York, Tennessee

Certification(s)/Specialty: Emergency 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:

The injured worker is a 54 year old female who sustained an industrial injury on 10/1/12. The mechanism of injury is unclear. She currently (12/29/12) complains of worsening left elbow pain. There is tenderness of the cervical and lumbar spine per physical examination. Medications were not specifically mentioned. Diagnoses include cervicothoracic spine strain; left cervical radicular syndrome; left shoulder girdle strain; left rotator cuff tendonitis with impingement syndrome; left lateral epicondylitis; left carpal tunnel syndrome; cervical disc protrusion at C4, 5, 6, 7; left, carpal tunnel syndrome. Treatments to date include left elbow injection without lasting relief. Diagnostics include electrodiagnostic studies upper extremities; MRI of the elbow; x-rays. Utilization Review dated 4/2/15 assessed transcutaneous electrical nerve stimulator unit and hot/ cold unit for cervical and lumbar spine. There is no available information addressing these issues.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of TENS Unit for cervical and lumbar:** 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 Interventions and Guidelines Page(s): 114-115.

**Decision rationale:** TENS units are not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, including reductions in medication use, for neuropathic pain, phantom limb pain, spasticity, and multiple sclerosis. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. Functional restoration programs (FRPs) are designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. In this case there is no documentation that the patient is participating in a FRP. In addition there is no documentation that the patient has had a successful one-month home trial with TENS unit. The request should not be authorized. Therefore, the requested treatment is not medically necessary.

**Purchase of Hot/Cold Unit for cervical and lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Lumbar and Thoracic, Cold/heat packs.

**Decision rationale:** MTUS does not address this topic. Cold/heat packs are recommended as an option for acute pain. At-home local applications of cold packs are recommended in first few days of acute complaint; thereafter, applications of heat packs or cold packs are recommended. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. While heat and cold packs are useful for low back pain, there is no recommendation that a Hot and Cold unit is necessary to supply the heat and cold applications to the affected area. Sufficient heat and cold can be applied with the use of hot packs, cold packs, or heating pad. There is no medical necessity for Hot and cold unit. The request should not be authorized. Therefore, the requested treatment is not medically necessary.