

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 11/17/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: DME TENS Unit E0730 purchase of 30 days rental

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas Board Certified Physical Medicine & Rehabilitation
Fellowship Trained Pain Management

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Initial consultation Healthcare Systems – no physician indicated 08/14/09
2. Examination findings Dr. D.C. 08/27/09
3. Examination findings Dr. 08/31/09
4. Insurance Company utilization review LVN, 09/11/09
5. Examination findings Dr. 09/14/09
6. Examination findings Dr. D.C. 09/16/09
7. Insurance Company utilization review 09/24/09
8. Examination findings Dr. 10/12/09
9. Examination findings Dr. D.C. 10/14/09
10. ***Official Disability Guidelines*** Texas Workman's Compensation Integrated Treatment/Disability Duration Guidelines 10/30/09

PATIENT CLINICAL HISTORY (SUMMARY):

The employee was evaluated on 08/14/09 at Healthcare Systems. The employee reported he was approaching a yield sign where he saw a vehicle coming so he stopped and was rear-ended. The employee reported he did not see the vehicle coming at the time of impact. He developed neck, shoulder and low back pain and reported going back to the office for a while. The employee reported that on 08/03/09, he went to Dr. who took him off of work until that day's evaluation. During that day's visitation, the employee complained of sharp neck pain which shot into bilateral shoulders, right greater than left. He was also experiencing numbness in hands, right greater than left which continues down to index and middle finger. He had been experiencing headaches everyday which initiated at the back of the head, usually worse in the morning. Aggravating factors included looking up. He had been wearing a cervical collar to decrease pain. The employee reported he has also been experiencing throbbing pain on the right side of his neck which radiates between the shoulders. His left-sided shoulder pain was described as a dull achiness down to his trapezius and right shoulder pain was sharp. Aggravating factors included activity. Alleviating factors included rest. The employee described the low back pain as a numbing discomfort which radiated to his left leg down to the top of his foot. Aggravating factors included bending. The rest of the note was difficult to read due to illegible writing. The rest of examination notes were difficult to read due to bad copy and illegible writing to make an accurate description of examination.

On 08/27/09, the employee was evaluated by Dr. The employee complained of neck pain and reported discomfort, constantly stiff and sore, with intermittent headaches which occur every two to three days, which had improved. Neck pain continued to be aggravated by looking up. Turning to the left shot pain into the right upper extremity and between his shoulder blades. He continued to experience numbness in his right upper extremity intermittently, and radial distribution changing positions of the arm made it subside, but it varies from incident to incident. Looking down seemed to increase numbness into the right hand. Numbness to the left upper extremity had subsided. He continued to have right shoulder pain intermittently with activity, described as deep and in the anterior and pain if he held his arm up which he was unable to drive with his right arm elevated on the steering wheel. Low back pain was unchanged, it was constant with numbness into the left leg; pain decreased with sitting and medications. On physical examination, deep tendon reflexes were 2+ bilaterally in the upper extremity. He continued to have good range of motion in the left wrist with no increase in pain on ulnar deviation. Right shoulder range of motion was measured at 95 degrees of flexion, 90 degrees of abduction, 48 degrees of internal rotation, 92 degrees of external rotation; strength continued to be diminished at the shoulder in flexion and abduction; the employee continued to be tender in the right anterior glenohumeral joint; positive Jump sign in the acromioclavicular joint; cervical spine range of motion was 30 degrees of flexion, this was an improvement by 10 degrees; 35 degrees of extension, an improvement by 5 degrees; 25 degrees of left lateral bending, showing an improvement of 5 degrees; 36 degrees of right lateral bending, showing an improvement of 6 degrees; 38 degrees of right rotation, an improvement of 18 degrees; 36 degrees of left rotation, an improvement of 8 degrees; the employee continued to have tenderness to palpation along the nuchal ligament and over the spinous processes of C5 through T5; moderate myospasm in the traps and anterior scaling on the right; bilateral shoulder depressor test was positive, right greater

than left; Spurling's was negative; Jackson's compression test was positive on the right, continued to have hypoesthesia along the C5-6 dermatomal level; range of motion of the lumbar spine revealed 40 degrees of flexion, 10 degrees of extension, 13 degrees of right lateral bending, 16 degrees of left lateral bending, the employee was able to heel and toe walk, seated root test was positive on the right and left; straight leg raise was positive on the left at 30 degrees; Kemp's was positive bilaterally; sensory abnormalities follow no particular dermatomal level under the left lower extremity. The assessment was posttraumatic cervical sprain/strain, cervical radiculitis, thoracic sprain/strain, lumbar sprain/strain, lumbar radiculitis, cervicogenic headaches, left shoulder acromioclavicular joint sprain/strain, right shoulder rotator cuff sprain/strain. The plan was that the employee had made minimal progress to date, MRIs of the cervical spine, lumbar spine, and right shoulder were going to be requested; order a brace for the lumbar spine; consider nerve conduction studies pending the MRI results; the employee would remain off work for an additional three weeks until diagnostic studies could be performed; begin the employee on some light active therapy.

On 08/31/09, the employee was seen by Dr. The employee was reported as a male employed where he was involved in a work related motor vehicle accident on xx/xx/xx. He was wearing a seatbelt while stopped at a yield sign. He had his head turned towards the left intending to make a left with oncoming traffic when he was suddenly struck from behind by another vehicle at high velocity. The employee immediately developed neck, bilateral shoulder, and low back pain.

The employee was taken to Hospital and was thereafter seen by his family practitioner Dr. on 08/03/09.

The employee is now in the care of Dr. the employee's treating doctor who referred him for medication management. On today's visitation, the employee possesses stiff intermittently sharp neck pain, which radiates principally into his right upper extremity with dysesthesias, numbness noted at his right thumb first and second digits. He has noticed mild decrease in handgrip strength. He also has bilateral dull achy shoulder pain, which radiates into his deltoid and upper arm. He complains of headaches that originate at the base of his skull and radiate occipitofrontally. He has dull achy stiff intermittently sharp low back pain, which radiates into his left lower extremity with dysesthesias over the entire leg, has not noted weakness. On physical examination the employee was wearing a cervical collar; gait was non-antalgic; cervical exam demonstrated rotation to the right to 40 degrees, to the left at 50 degrees, flexion to 35 degrees, extension to 20 degrees, right and left lateral bending to 25 degrees; positive Jackson compression test on the right; negative cervical distraction test; right sided C2 through T1 hypesthesia; left sided C7 hypesthesia; reduced right upper extremity motor strength of 4/5 at C5, C6, and C7 motor nerve roots; normal sensory on the left; +2 deep tendon reflexes bilaterally; the employee was tender to palpation at C4-5, C5-6, and C6-7 interspaces bilaterally, right greater than left; there was a moderate degree of paracervical and parathoracic myospasticity. Examination of his left shoulder demonstrated abduction to 160 degrees, flexion to 180 degrees, internal rotation to 80 degrees, external rotation to 75 degrees; negative Neer's impingement test; negative empty can test; negative apprehension, belly press, and Yergason's tests; strength was 5/5. Right shoulder revealed abduction to 130 degrees, flexion to 150 degrees, internal rotation to 70 degrees, external rotation to 65 degrees; positive Neer's impingement

test; positive apprehension test; negative Yergason's, apprehension, and belly press test. Chest was clear to auscultation in all fields. Heart showed regular rate and rhythm without murmur or gallop. Abdomen was soft, non-tender, and no distention. No masses were palpated. Bowel sounds are present and normal. Lumbar examination demonstrated mild paralumbar myospasticity; tenderness at L5-S1 facet bilaterally, left greater than right; negative bilateral Kemp's test; the absence of facet pain on axial loading; left sided L4-S1 hypesthesia; right sided L4 hypesthesia; normal motor examination bilaterally; +2 deep tendon reflexes bilaterally; negative straight leg raise test in the sitting position; pedal pulses are +2 bilaterally; lumbar flexion to 60 degrees, extension to 15 degrees, right and left lateral bending to 25 degrees. The remainder of his neurologic examination was essentially normal. The assessment was cervical sprain/strain with radiculitis, cervicogenic headaches, bilateral shoulder sprain/strain, and right shoulder impingement, rule out internal derangement, lumbar sprain/strain with radiculitis, probably cervical intervertebral disc disease. The plan was to obtain entirety of old medical records from Hospital. Obtain right shoulder and cervical MRI, EMG/NCV of upper extremities. The employee was to continue physical therapy three days per week under the care of Dr. Prescriptions for Norco 10/325 mg one p.o. tid, Skelaxin 800mg one p.o. tid, Myloxiam 15mg one p.o. qd were given. A TENS unit was ordered, along with a lumbar support belt and Biofreeze two tubes. Follow-up in two weeks.

On 09/14/09, the employee underwent an examination by Dr. He continued to complain of sharp neck pain with radiation to the right upper extremity with dyesthesias. Numbness was noted at the right thumb as well as second and third digits. He complained of dull, achy, intermittent sharp low back pain which radiated into the left lower extremity with dyesthesias noted over the entire leg. He had not noted any weakness. He rated his pain 7/10 off medications, 5-6/10 with current medications. The employee was requesting refills. The employee's cervical pain was on the right and his lumbar pain was on the left. On examination the employee was wearing a cervical neck brace. Cervical examination demonstrated rotation to the right 45 degrees, to the left 50 degrees, flexion to 30 degrees, extension to 20 degrees, right and left lateral bending to 25 degrees; positive Jackson's compression test on the right; negative cervical distraction test; right sided C2 through T1 hypesthesia; mild left sided C7 hypesthesia; reduced right upper extremity motor strength at C5, C6, and C7 motor nerve roots of 4 $\frac{3}{4}$ /5; normal sensory and motor examination on the left; +2 deep tendon reflexes bilaterally. Shoulder and lumbar examinations were deferred. MRI of the cervical spine was obtained on 09/04/09. It showed multilevel degenerative changes most notable at C5-C6 and C6-C7 with central and left paracentral disc bulges of 4 mm at C5-C6 and central and paracentral disc bulge of 3 mm at C6-C7 narrowing the spinal canal to 9 mm with mild right foraminal narrowing. MRI of the right shoulder on 09/04/09 revealed mild tendinopathy of the supraspinatus and subscapularis tendons; mild acromioclavicular joint reactive change. MRI of the lumbar spine on 09/04/09 revealed multilevel degenerative changes most notable at L5-S1 for a central and paracentral disc bulge of 3 mm. Mild to moderate facet arthropathy, moderate left foraminal narrowing, and mild right foraminal narrowing were also noted. Assessment was cervical facet syndrome with myelopathy, cervicogenic headaches, bilateral shoulder sprain/strain, right shoulder impingement with acromioclavicular joint arthrosis and supraspinatus and subscapularis tendinopathy, lumbar sprain/strain, lumbar facet syndrome, and lumbar intervertebral disc disease at L5-S1. The plan was to refer the

employee for lumbar and cervical epidural steroid injections. The employee was to continue physical therapy three days per week. A prescription for Norco, Skelaxin, and Myloxiam were given. Performance of EMG/NCV of upper and lower extremities was pending; follow-up in one month.

On 09/16/09, the employee was evaluated by Dr. The employee had trouble standing for longer than five minutes yesterday causing increased tingling and numbness into his left leg predominantly into the big toe. He reported an aching in his left hip joint, sitting and elevating his leg decreased the numbness in his left leg. He had pain going from his low back into his hip. The employee also continued to have neck pain described as a constant dull ache intermittently sharp and shooting with extension and bilateral rotation of the cervical spine, radiates into the right arm and down between his shoulder blades. Numbness was primarily into the right thumb, index, and middle finger. The employee was left hand dominant. He did report improvement in his headaches, as they are less frequent and decreased in intensity. Pain in his right shoulder with activity and relieved by rest was noted. On physical examination the employee continued to have good range of motion at the wrist bilaterally; right shoulder range of motion was measured at 98 degrees of abduction, 48 degrees of internal rotation, 92 degrees of external rotation; strength at the shoulder was 4/5 in abduction and internal rotation; he had a positive Jump sign at the anterior glenohumeral joint and acromioclavicular joint; drop arm test was negative; Neer's impingement was positive; cervical range of motion was 40 degrees of flexion, 38 degrees of extension, 30 degrees of left lateral bending, 38 degrees of right lateral bending, 52 degrees of right rotation 50 degrees of left rotation; the employee showed improvement in all fields of range of motion with regard to his shoulder and cervical spine; the employee continued to have cervical palpation tenderness at C5 through T5; myospasms in the bilateral traps and right parascapular; he had a positive shoulder depressor test on the right; Spurling's was negative; Jackson's compression test was positive on the right; there was hypoesthesia along the C5 and C6 dermatomal level; range of motion of the lumbar spine reveals 40 degrees of flexion, 10 degree of extension, 13 degrees of right lateral bending, and 15 degrees of left lateral bending; the employee was able to heel and toe walk; seated root test was positive on the left; straight leg raise was positive on the left at 35 degrees; Kemp's was positive bilaterally; sensory abnormalities were along the L5 dermatomal level. Assessment was posttraumatic cervical sprain/strain, cervical radiculitis, thoracic sprain/strain, lumbar sprain/strain, lumbar radiculitis, and right shoulder rotator cuff sprain/strain. The plan was the MRI revealed some foraminal encroachment on the right in the cervical spine and the left in the lumbar spine, also revealed some tendinopathy in the shoulder. The employee has been referred by Dr. for consideration of selective injections. The employee had a total of five remaining physical therapy sessions; he had also been referred for an EMG/NCV of his upper and lower extremities by Dr. The upper as been approved and we are awaiting approval of lower. The employee may require a referral for neurosurgical consult if the injections are not successful. The employee would remain off work for an additional month. The employee did report some improvement through the use of his lumbar bracing. The employee continued to wear his cervical collar when performing activities.

On 10/12/09, the employee was seen by Dr. The employee continued to complain of sharp neck pain radiating to his right upper extremity with dysesthesias, noted

numbness at his right thumb, as well as second and third digits. He has mildly reduced handgrip strength; bilateral dull ache shoulder pain, right greater than left, which radiates into his right arm. The employee also complained of lumbar lower back pain which radiated into his left buttocks down to the left lower extremity with dysesthesias. He rated his pain 7-8/10 off medications, 4-5/10 on medications. Examination of the lumbar spine demonstrated flexion to 55 degrees, extension 13 degrees, right and left lateral bending to 25 degrees; L4 through S1 facet tenderness bilaterally, left greater than right ; positive left sided Kemp's test; left SI joint tenderness, which is moderately provocative; positive left sided Faber's; left sided L4 through S1 hypesthesia; normal sensory exam on the right; normal motor exam bilaterally; 2+ deep tendon reflexes bilaterally; mild facet pain on axial loading; negative straight leg raise test in the sitting position. Cervical and right shoulder exams were deferred. EMG/NCV of the upper and lower extremities was performed on 10/01/09. The studies showed mild to moderately severe left peroneal mononeuropathy at or above the knee, otherwise no radiculopathy, plexopathy, or peripheral neuropathy noted at the upper and lower extremities. MRI of the lumbar spine was reviewed from 09/04/09. Assessment was lumbar sprain/strain, lumbar facet syndrome, lumbar intervertebral disc disease, cervical facet syndrome with myelopathy, cervicogenic headaches, bilateral shoulder sprain/strain, and right shoulder impingement with acromioclavicular joint arthrosis and supraspinatus subscapularis tendinopathy. Plan: Dr. was not able to obtain a response from Dr. The employee was referred to Dr. for cervical and lumbar injections; continue with physical therapy three days per week; prescribe Norco, Skelaxin, Myloxiam, and Cymbalta. The employee was to continue off to work duty status. His disability was completed to that extent. Follow up in one month.

On 10/14/09 the employee was seen by Dr. The employee complained that his radiating pain into his left leg was getting worse involving the whole leg. The pain radiated predominantly into the big toe and second toe. Neck pain is unchanged with continued pain into the right thumb and index finger. Shoulder pain is described as a dull achiness. Lumbar spine pain has increased since discontinuing therapy. The employee has not heard from Dr. and has changed providers for selective injections to Dr. in hopes of leaving his care. On physical examination right shoulder range of motion is mildly improved 100 degrees of flexion, 105 degrees of abduction, 48 degrees of internal rotation, and 92 degrees of external rotation. Strength at the shoulder is 4/5 with abduction and internal rotation. He continues to have a positive jump sign at the anterior glenohumeral joint and at the acromioclavicular joint. Drop arm test is negative, Neer impingement test is positive. Cervical range of motion is decreased 36 degrees of flexion, 30 degrees of extension, 28 degrees of left lateral bending, 34 degrees of right lateral bending, 52 degrees of right rotation and 50 degrees of left rotation. He is left hand dominant with poor grip strength bilaterally. Jackson's compression test is positive on the right. There is hypoesthesia along the C5-6 dermatomal level. Range of motion in the lumbar spine reveals 40 degrees of flexion, 8 degrees of extension, 12 degrees of right lateral bending, 13 degrees of left lateral bending. The employee is able to heel and toe walk. Seated root test is positive on the left. Strength testing at the ankle, dorsiflexion, and plantar flexion is 4/5. Hip flexion in the left is 4/5. Assessment was posttraumatic cervical sprain/strain, cervical radiculitis, thoracic sprain/strain, lumbar sprain/strain, lumbar radiculitis, right shoulder rotator cuff sprain/strain. Plan was to refer the employee to Dr. for the consideration of selective injections, once those had been accomplished, the employee would return for post injection therapy, and hopefully return to full duty.

On 09/11/09, insurance company filed a utilization review to determine the accordance with applicable DWC rules and the insurance code utilization review requirements. Diagnosis was neck sprain. Treatments and services requested were DME TENS unit E0730 purchase of 30 day rental. The utilization review decision was non-certified by Dr. Prado as she indicated that there was no evidence of efficacy or objective improvement from a prior trial or care with the requested unit to support and warrant the its use.

On 09/24/09, Insurance Company filed a utilization review for treatment and services requested which was appeal DME TENS unit E0730 purchase for 30 day rental. Utilization review decision was non-certified by D.C., who indicated the same findings and recommendations as Dr.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Agreement is made with the previous reviews. There is little evidence to support TENS as an isolated modality unless there is evidence of functional improvement with a supervised trial. Improvements such as increased motion, mobility, decreased medicinal use, etc should be evaluated during the trial. At this time, and in consideration of the records and facts presented, there is little supportive evidence to recommend overturning the prior denials.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

1. **Official Disability Guidelines**, Neck Chapter, Shoulder Chapter, Pain Chapter and Low Back Chapter, online version
2. Carroll D, Moore RA, McQuay HJ, Fairman F, Tramer M, Leijon G, Transcutaneous electrical nerve stimulation (TENS) for chronic pain, *Cochrane Database Syst Rev.* 2001;(3):CD003222.
3. [Poitras S, Brosseau L](#). Evidence-informed management of chronic low back pain with transcutaneous electrical nerve stimulation, interferential current, electrical muscle stimulation, ultrasound, and thermotherapy. *Spine J.* 2008 Jan-Feb;8(1):226-33.