

Case Number:	CM13-0044217		
Date Assigned:	12/27/2013	Date of Injury:	09/09/2011
Decision Date:	05/16/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/28/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 physician 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:

This 59 year-old female sustained an injury when she tripped over a child on 9/9/11 while employed by [REDACTED]. Initial diagnoses included right knee contusion and left ankle sprain. Request under consideration include an Interferential Stimulator Unit. Report of 1/2/13 from a provider noted patient with continued complaints of left ankle pain s/p surgical repair. Conservative care has included physical therapy, medications, injections and brace/wraps. Exam of left ankle/ foot noted normal appearance, tenderness about the peroneal tendons; motor strength intact; range of motion within normal limits and causes no pain; sensation normal; Negative Tinel's; brisk capillary refills with normal gait without instability. Impression included peroneal tendinitis; Knee DJD; ankle sprain; f/u surgery. Plan included full length orthoses for peroneal tendinitis. There is certificate of medical necessity form letter from current requesting provider for the IF stimulator for diagnoses of right knee strain and left ankle sprain. Previous treatment checked boxes included NSAIDS and pain medications and use of this IF unit 3-6 months. Request for IF unit was non-certified on 9/30/13 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF UNIT: 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 SECTION ON TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION, (TENS), FOR CHRONIC PAIN Page(s): 114-11.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of a TENS Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. It appears the patient has received extensive conservative treatment to include medications, modified work and rest, and physical therapy. There is no documentation on what IF unit is to be used, the functional improvement from treatment trial of TENS unit, nor is there any documented short-term or long-term goals of treatment with the IF unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the IF Unit. There is no evidence for change in work status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the physical therapy treatment already rendered. The IF unit is not medically necessary and appropriate.