

Case Number:	CM13-0044531		
Date Assigned:	12/27/2013	Date of Injury:	09/04/2012
Decision Date:	02/28/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	10/30/2013

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 47 year-old patient sustained a repetitive injury on 9/4/12 while employed by [REDACTED]. A report by [REDACTED] dated 7/16/13 noted that the patient had complaints of left wrist, low back, and left hip pain with associated difficulties sleeping. The claimant was not participating in any work activities. The patient has received 12 sessions of physical therapy. Exam showed full range of motion of upper and lower extremities, normal gait patten. Lumbar x-rays of lumbar spine were consistent with narrowing at L5-S1 disc space with osteophyte formation; x-rays of left hip showed mild degenerative changes; x-rays of left wrist showed no abnormalities. A report dated 8/7/13 noted that the claimant is not participating in work activities with exam findings of tenderness over left wrist, left hip, and low back.

IMR ISSUES, DECISIONS AND RATIONALES

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

The request for a TENS unit for purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 114-117.

Decision rationale: Per the MTUS Chronic Pain 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 a trial in adjunction to ongoing treatment modalities 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 TENS unit is to be purchased and its functional improvement from treatment trial, neither is there any documented short-term or long-term goals of treatment with the TENS 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 TENS unit. There is no evidence for change in work status, increase in activities of daily living, decreased VAS score, medication usage, or treatment utilization from the physical therapy treatment already rendered. The TENS unit for purchase is not medically necessary and appropriate.