MAXIMUS Federal Services

Case Number:	CM13-0065991		
Date Assigned:	01/03/2014	Date of Injury:	08/28/2012
Decision Date:	05/19/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/16/2013

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. The expert 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 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/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 33 year-old female sustained an injury on 8/28/12 while employed by [redacted]. Requests under consideration include RETRO TENS UNIT, RETRO ELECTRODES 8 PAIRS PER MONTH, and RETRO BATTERIES 6 UNITS PER MONTH. Cervical spine MRI dated 2/15/13 documented small disc protrusion at C5-6 without significant spinal or foraminal stenosis; EMG/NCS of 1/14/12 was unremarkable. Conservative care has included medications, chiropractic care, 16 physical therapy visits, and wrist wrap. Medications list Norco, Omeprazole, and Tizanidine. Report of 9/24/13 from the provider noted patient with complaints of neck and right arm pain rated at 6-7/10 with persistent right hand numbness. Exam of the cervical spine showed paracervical tenderness along sternocleidomastoid, suprascapular, trapezius, and rhomboid muscles; range of motion is full with some discomfort; weakly positive axial loading/spurling testing; right elbow with tenderness over medial and lateral epicondyle; right wrist with positive Tinel's, Phalen's and finkelstein testing. Diagnoses included cervical radiculpathy; cervicalgia; lateral epicondylitis; and right wrist tenosynovitis. Retrospective requests for above TENS unit and accessories were non-certified on 11/27/13 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:

RETRO TENS UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS. Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-118.

Decision rationale: This 33 year-old female sustained an injury on 8/28/12 while employed by [redacted]. Requests under consideration include RETRO TENS UNIT, RETRO ELECTRODES 8 PAIRS PER MONTH, and RETRO BATTERIES 6 UNITS PER MONTH. Cervical spine MRI dated 2/15/13 documented small disc protrusion at C5-6 without significant spinal or foraminal stenosis; EMG/NCS of 1/14/12 was unremarkable. Report of 9/24/13 from the provider noted patient with ongoing complaints of neck and right arm pain rated at 6-7/10 with persistent right hand numbness. Exam of the cervical spine showed tenderness with full range of motion. Diagnoses included cervical radiculpathy; cervicalgia; lateral epicondylitis; and right wrist tenosynovitis. Per 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 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 TENS unit is to be purchased or rented for what duration, its fucntional improvement from treatment trial, nor 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, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the physical therapy treatment already rendered. The RETRO TENS UNIT is not medically necessary and appropriate

RETRO ELECTRODES 8 PAIRS PER MONTH: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation cms.gov/medicare-coverage-database; and National Coverage Determination (NCD) for Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neurosmuscular Electrical Stimeulation (NMES) (160.13).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-118.

Decision rationale: Please see rationale #1. As tens unit is not medically necessary and appropriate thereby all accessories of batteries and electrodes are not medically and appropriate.

RETRO BATTERIES 6 UNITS PER MONTH: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation cms.gov/medicare-coverage-database; and National Coverage Determination (NCD) for Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neurosmuscular Electrical Stimeulation (NMES) (160.13).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-118.

Decision rationale: Please see rationale #1. As tens unit is not medically necessary and appropriate thereby all accessories of batteries and electrodes are not medically and appropriate.