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| Case Number: | CM13-0069827 | | |
| Date Assigned: | 01/08/2014 | Date of Injury: | 11/08/2012 |
| Decision Date: | 05/22/2014 | UR Denial Date: | 11/18/2013 |
| Priority: | Standard | Application Received: | 12/23/2013 |

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 Texas. 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:

The injured worker is a 38 year old female who was injured on 11/08/2012 due to a fall. Clinical note dated 11/18/2013 reports low back pain in the lateral gluteal areas and mid back pain. Physical exam consists of the right elbow having tenderness to palpation over the Olecranon process and proximal aspect of the forearm. The lumbar range of motion values on 12/18/2012 were 34 degrees of flexion, 12 degrees of extension, 27 degrees of left lateral flexion and 14 degrees of right lateral flexion. The lumbar range of motion values on 01/23/2013 were 40 degrees of flexion, 16 degrees of extension, 21 degrees of left lateral flexion, and 18 degrees of right lateral flexion. Treatment included chiropractic treatment and use of a Med-3 unit. The patient's diagnosis is Sprain/Strain Lumbosacral, Sprain/Strain Thoracic Region, and Sprain/Strain Knee/Leg.

IMR ISSUES, DECISIONS AND RATIONALES

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

**MEDS-3 UNIT X 4 MONTH RENTAL(WILL BE PURCHASE AFTER RENTAL)
ELECTRODES X 16, TO BE DISPENSED 11/16/13: Upheld**

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation Page(s): 114.

Decision rationale: The California MTUS guidelines do not recommend this request 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. The request is for a 4 month rental exceeds the recommendation of one month. The request for a MEDS-3 unit, 4 month rental is not medically necessary and appropriate.

ELECTRODES, QUANTITY 16: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.