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| Case Number: | CM13-0071273 | | |
| Date Assigned: | 01/08/2014 | Date of Injury: | 07/17/2013 |
| Decision Date: | 06/12/2014 | UR Denial Date: | 12/16/2013 |
| Priority: | Standard | Application Received: | 12/27/2013 |

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 Anesthesiologist Pain Medicine and is licensed to practice in Florida. 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 35-year-old male who reported an injury on 07/17/2013. The mechanism of injury was not specifically stated. Current diagnoses include cervical radiculitis, cervical myofascial sprain, lumbar myofascial sprain, lumbar/lumbosacral disc degeneration, and lumbar herniated nucleus pulposus. The injured worker was evaluated on 01/13/2014. The injured worker reported persistent lower back pain with radiation to the right lower extremity. Physical examination revealed tenderness to palpation of the cervical spine, limited cervical range of motion, tenderness to palpation of the lumbar paravertebral muscles, limited lumbar range of motion, positive straight leg raising, 5/5 motor strength in bilateral lower extremities, and intact sensation. Treatment recommendations at that time included authorization for a home TENS unit for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

PURCHASE OF HOME TENS UNIT: Upheld

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

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

Decision rationale: The California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality but a 1 month home-based trial may be considered as a noninvasive conservative option. There should be evidence that other appropriate pain modalities have been tried and failed. There should also be documentation of a treatment plan, including the specific short and long-term goals of treatment with the unit. As per the documentation submitted, there is no evidence of a successful 1 month trial period with the TENS unit prior to the request for a unit purchase. There is also no mention of a failure to respond to other appropriate pain modalities. There is no evidence of a treatment plan including the specific short and long-term goals. Based on the clinical information received and the California MTUS Guidelines, the request is not medically necessary.