MAXIMUS Federal Services

Case Number:	CM14-0003069		
Date Assigned:	01/29/2014	Date of Injury:	05/13/2011
Decision Date:	06/19/2014	UR Denial Date:	12/24/2013
Priority:	Standard	Application Received:	01/08/2014

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, has a subspecialty in Pain Medicine, and is licensed to practice in Texas and Ohio. 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 60-year-old male with a reported date of injury on May 13, 2011. The injured worker complained of neck pain and right knee pain. The injured worker's pain was rated 7/10. The cervical MRI dated October 5, 2011 revealed disc bulges at C4-5, C5-6and C6-7. The injured worker's right knee demonstrated flexion to 125 degrees. The injured worker's cervical spine showed extension to 80 degrees. According to the clinical note dated November 13, 2013, the injured worker underwent a cervical spine epidural steroid injection, with 50% relief of pain. The injured worker's diagnoses included status post right knee arthroscopy, sprain of the cervical spine with disc bulges, sprain of the lumbar spine with lower extremity radiculitis, shoulder tendonitis, cubital tunnel syndrome, carpal tunnel syndrome of the right wrist and history of diabetes. The injured worker's medication regimen included methocarbamol, tramadol, ibuprofen, omeprazole, cyclobenzaprine, and Ambien. The request for Authorization for the electrical stimulation unit rental for five months was submitted on January 3, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTRICAL STIMULATION UNIT RENTAL FOR 5 MONTHS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL

TREATMENT GUIDLINES, TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS),

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines transcutenaeous electrotherapy Page(s): 114-116.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, transcutaneous electrical nerve stimulation (TENS) is not recommended as a primary treatment modality. A one month home-based TENS trial may be considered as a noninvasive conservative option if used in conjunction with a program of evidence-based functional restoration, including physical therapy. The request did not specify the site at which the TENS unit was to be utilized. According to the documentation dated November 20, 2013, the physician noted the injured worker is not attending therapy. It was unclear if the injured worker underwent a one month home based TENS trial with documented efficacy prior to the request for five months of treatment. It was unclear if the TENS unit would be used in adjunct with an evidenced-based program of functional restoration. Electrical stimulation unit rental for five months exceeds the recommended guidelines. The request for an electrical stimulation unit rental for five months is not medically necessary or appropriate.