

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0008313 | | |
| Date Assigned: | 02/12/2014 | Date of Injury: | 03/17/2001 |
| Decision Date: | 06/24/2014 | UR Denial Date: | 12/30/2013 |
| Priority: | Standard | Application Received: | 01/22/2014 |

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California and Nevada. 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 53 year old female whose date of injury is 03/17/2001. The mechanism of injury is not described. Office visit note dated 06/12/13 indicates that coccygeal pain has recurred. The documentation notes a failed back syndrome (status post L4-5 and L5-S1 anterior interbody fusion), thoracic or lumbosacral neuritis or radiculitis, coccydynia resolved with caudal epidural, status post trial of spinal cord stimulator with 50+% pain relief, associated mood disorder and sleep disorder. A note dated 10/21/13 indicates medications include Cymbalta, MS Contin, Norco and Tizanidine. The follow up note dated 11/27/13 indicates low back pain is rated as 5/10.

IMR ISSUES, DECISIONS AND RATIONALES

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

PURCHASE OF TENS UNIT WITH SUPPLIES FOR THE LOW BACK: Upheld

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

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

Decision rationale: Based on the clinical information provided, the request is for purchase of a Transcutaneous Electronic Nerve Stimulator (TENS). As required by California Medical

Treatment Utilization Schedule (CAMTUS) guidelines, the patient must undergo a successful trial of Transcutaneous Electronic Nerve Stimulator (TENS) before purchase. The injured worker was authorized for a one month trial of TENS; however, the injured worker's objective functional response to the trial is not documented. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals were provided. Therefore this request is not medically necessary.