

Case Number:	CM14-0154666		
Date Assigned:	09/24/2014	Date of Injury:	03/12/2001
Decision Date:	10/27/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/22/2014

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 Orthopedic Surgery, has a subspecialty in Spine Surgery, 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:

The patient has chronic pain in the cervical spine, lumbar spine right shoulder and bilateral knees. She reports worsening of pain despite taking medications. She takes narcotics. On physical examination she has decreased range of motion of the neck with tenderness to palpation the neck. Spurling sign is positive. She has normal motor strength. She has decreased sensation on the left side. Deep tendon reflexes are normal. Low back examination reveals decreased range of motion of the back. Straight leg raising is positive on the right. There is decreased sensation L4 and L5 dermatomes and normal motor strength. Bilateral knees show decreased range of motion right greater than left. Is positive patellar grind and McMurray test. X-rays of the knees show posttraumatic arthritis on the right and medial compartment arthritis on the left. Patient is diagnosed with posttraumatic knee arthritis and she's had arthroscopic surgery on the right side. She has left knee arthritis and right shoulder rotator cuff syndrome. She has cervical disc degeneration and lumbar spinal stenosis and has had a laminectomy. At dispute is whether a TENS unit is medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prime Dual Nerve Stimulator TENS (Transcutaneous Electrical Nerve Stimulation)/ EMS (Electric Muscle Stimulation) unit, QTY: 1 month: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: MTUS low back Chapter, ODG low back chapter

Decision rationale: This patient does not meet establish criteria for TENS unit. A TENS unit is not recommended as a primary treatment modality. There is no documentation medical records that the patient involved in a functional restoration program. More documentation the medical records as to the amount of conservative measures and type of conservative measures for the patient chronic neck, back, shoulder and knee pain must be documented. At the present time criteria for TENS unit is not medically necessary. The medical records do not include documentation of a recent trial of failure conservative measures to include physical therapy. More documentation is necessary as a TENS unit is not recommended as an isolated treatment intervention and is only appropriate when used in conjunction with other active evidence base functional rehabilitation program modalities. Therefore, this request is note medically necessary.

Electrodes, Batteries and Lead Wires, QTY: 2 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: MTUS low back Chapter, ODG low back chapter

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