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| Case Number: | CM14-0026557 | | |
| Date Assigned: | 06/13/2014 | Date of Injury: | 12/24/2012 |
| Decision Date: | 07/16/2014 | UR Denial Date: | 01/30/2014 |
| Priority: | Standard | Application Received: | 03/03/2014 |

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 and is licensed to practice in 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 50-year-old female injured on December 24, 2012. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated April 2, 2014, indicated that there were ongoing complaints of low back pain and left hip pain. It was stated that the injured employee's previous left forearm pain and neck pain have resolved. The physical examination demonstrated normal neurological examination. A request had been made for a transcutaneous electrical nerve stimulation (TENS) unit and a cold compression therapy unit and was not certified in the pre-authorization process on January 30, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) UNIT 30 DAY RENTAL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-115.

Decision rationale: A TENS unit is not recommended 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. It is intended for use for neuropathic pain. According to the most recent medical record, the injured employee's symptoms of neuropathic pain have resolved, and there was a normal neurological examination. Therefore, this request for a TENS unit is not medically necessary.

COLD PNEUMATIC COMPRESSION THERAPY UNIT 30 DAY RENTAL: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 1044-1046.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Knee & Leg (Acute & Chronic) and Cold Compression Therapy Unit.

Decision rationale: According to the Official Disability Guidelines, a cold compression therapy unit is only indicated for use for the knee. This may have been previously recommended for the injured employee's upper extremity, but according to the most recent medical record, these symptoms have resolved. There are current complaints of back and hip pain, and a cold compression unit is not recommended for back or hip pain. For these multiple reasons, this request for a cold compression unit is not medically necessary.