MAXIMUS Federal Services

Case Number:	CM14-0030846		
Date Assigned:	04/09/2014	Date of Injury:	09/10/2010
Decision Date:	05/08/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	01/28/2014

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 & Rehabilitation 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 injured worker is a 50-year-old male who reported an injury on 09/10/2013, following a motor vehicle accident. Current diagnoses include lumbosacral spondylosis without myelopathy, degeneration of lumbosacral intervertebral disc, lumbago, thoracic/lumbosacral neuritis/radiculitis, spasm, unspecified myalgia and myositis, and closed fracture without spinal cord injury. The injured worker was evaluated on 01/13/2014. The injured worker reported severe mid back pain, left hip pain, left shoulder pain, left clavicle fracture pain, and low back pain. Physical examination revealed thoracic paraspinal muscle tenderness, severe burning pain to the left anterior thigh, an ataxic gait, normal strength in bilateral lower extremities, and radicular/facet pain. Treatment recommendations included continuation of current medication, a spinal surgeon consultation, and a TENS unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS UNIT RENTAL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a one month home-based trial may be considered as a non-invasive conservative option. There should be evidence that other appropriate pain modalities have been tried and failed. As per the documentation submitted, there is no indication of an exhaustion of conservative treatment prior to the request for TENS therapy. There is also no evidence of a treatment plan including the specific short and long-term goals of treatment with the TENS unit. The specific frequency and duration of treatment was not provided in the request. Therefore, the request cannot be determined as medically appropriate. As such, the request is non-certified.