

Case Number:	CM14-0052407		
Date Assigned:	07/07/2014	Date of Injury:	04/30/2001
Decision Date:	09/16/2014	UR Denial Date:	03/31/2014
Priority:	Standard	Application Received:	04/21/2014

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 Management and is licensed to practice in Tennessee. 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:

This 71 year old patient had a date of injury on 4/30/2001. The mechanism of injury was when she fell from a chair and landed on her right lower back. In a progress noted dated 3/4/2014, subjective findings included constant low back pain radiating to the left lower extremity with numbness and tingling, right shoulder pain, elbow pain, and wrist pain. Pain without medication is 9-10/10 and with medications, 7/10. On a physical exam dated 3/4/2014, objective findings included tender lumbar spine with spasm, right upper extremity sensation decreased at c6-c5, mild antalgic gait. Diagnostic impression shows lumbar stenosis, radiculopathy and spondylolisthesis, right shoulder rotator cuff tear, right elbow internal derangement, and right carpal tunnel syndrome. Treatment to date: medication therapy, behavioral modification, surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transcutaneous Electrical Nerve Stimulation Unit with Supplies: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy.

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

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines state that TENS units are not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. Criteria for the use of TENS unit include Chronic intractable pain - pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, and a treatment plan including the specific short- and long-term goals of treatment with the TENS unit. CA MTUS Chronic Pain Medical Treatment Guidelines state that a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function and that other ongoing pain treatment should also be documented during the trial period including medication. In a progress report dated 3/4/2014, it appears that the pain is adequately controlled with medication(7/10 with medication as opposed to 9-10/10 without) In the reports viewed, there was no discussion regarding failure of conservative treatments such as medication therapy and behavioral modification. Furthermore, there was no rationale provided regarding the objective functional goals intended for TENS unit, and why this TENS unit is necessary in this patient's particular treatment regimen. Therefore, the request for TENS unit with supplies is not medically necessary.