

Case Number:	CM14-0078326		
Date Assigned:	07/18/2014	Date of Injury:	03/02/2011
Decision Date:	09/15/2014	UR Denial Date:	05/17/2014
Priority:	Standard	Application Received:	05/28/2014

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 and 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 38-year-old male who reported an injury on 03/07/2011. The mechanism of injury was not provided with the documentation submitted for review. His diagnoses were noted to be lumbar degenerative disc disease and lumbar radiculopathy. Prior treatments were noted to be medications, therapy and transcutaneous electrical nerve stimulation. Diagnostic were noted to be electromyography/nerve conduction velocity study and magnetic resonance imaging. He was noted to medications of cyclobenzaprine, Naproxen and Omeprazole. The injured worker had an evaluation on 05/12/2014. Objective complaints were noted to be low back pain rated a 7/10 on the pain scale. The objective findings on the physical exam were the injured worker was alert and oriented with a normal gait. There was tenderness to palpation of the lumbar spine. The treatment plan was for refill of medications and a follow-up appointment. The provider's rationale for the request was noted within the clinical note. A Request for Authorization form was not provided with this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-116.

Decision rationale: The request for TENS unit is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend transcutaneous electrical nerve stimulation as a primary treatment modality, but a 1 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. The documentation submitted for review does not indicate a program of evidence based functional restoration. In addition, the provider failed to indicate a 1 month home based trial within the request. Therefore, the request for TENS unit is not medically necessary.