

Case Number:	CM14-0079156		
Date Assigned:	07/18/2014	Date of Injury:	09/15/2011
Decision Date:	09/19/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	05/29/2014

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 Illinois. 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 54-year-old male who reported an injury on 09/15/2011. The mechanism of injury was not provided. On 05/06/2014, the injured worker had presented with bilateral knee, right wrist, right shoulder and back pain. Diagnostic studies included x-ray of the bilateral knee performed 02/14/2014 which revealed right knee moderate advanced medial compartment osteoarthritis and left knee moderate advanced medial and mild lateral compartment osteoarthritis. Upon examination, the injured worker did not exhibit any acute distress, anxiety, confusion, or fatigue. There was normal muscle tone in the bilateral upper and bilateral lower extremities. There was no swelling observed. The diagnoses were pain in the joint, shoulder, pain in the joint hand and pain in the joint lower leg. Prior therapy included medications, surgery and physical therapy. The provider recommended 30 use of TENS unit/supplies, the provider's rationale was not provided. The Request for Authorization Form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 USE OF TENS UNIT / SUPPLIES: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENs Page(s): 116.

Decision rationale: The California MTUS Guidelines do not recommend the use of a TENS unit as a primary treatment modality. A 1-month home-based TENS trial may be considered as a noninvasive option if used as an adjunct to a program of evidence-based functional restoration. The results of studies are inconclusive, published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief nor do they answer questions about long term effectiveness. There is lack of documentation indicating significant deficits upon physical examination. The efficacy of the injured worker's previous questions of concern for treatment were not provided. It was unclear if the injured worker underwent an adequate TENS trial. The request is also unclear if the injured worker needed to rent or purchase the TENS unit. The provider's request does not indicate the site that the TENS unit is indicated for in the request as submitted. As such, the request is not medically necessary.