

<b>Case Number:</b>	CM14-0080084		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	10/12/2009
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	05/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/30/2014

### 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:

This 50 year-old patient sustained a cumulative trauma injury on 10/12/09 while employed by [REDACTED]. Request under consideration include [REDACTED] Stimulator Unit Purchase and Stimulator Supplies of lead wires, batteries x months, QTY: 3 and conductive garment, QTY: 2. The patient is s/p left shoulder arthroscopic surgery (undated); s/p left knee arthroscopic surgery x3 (2 done prior to employment); s/p right eye laser surgery (undated). Conservative care has included LESI, medications, physical therapy, and activity modification/rest. The patient has been retired per AME in 2009. Orthopedic AME report of 4/23/13 noted patient to be P&S with future medical to include medications, injections and follow-up for exacerbation. Report of 11/22/13 from the provider noted the patient with chronic left shoulder, bilateral knee, lumbar spine and cervical spine pain rated on VAS of 7/10. Medications list Norco which was refilled. Patient had left upper back injections of Lidocaine/Depo Medrol at points identified. Report of 2/17/14 from the provider noted the patient with right knee and low back pain; currently working. Request was referral to another provider for hypertension treatment. Report of 4/1/14 from the provider noted recommendation for [REDACTED] stimulator without substitution. The request for [REDACTED] Stimulator Unit Purchase and Stimulator Supplies of lead wires, batteries x months, QTY: 3 and conductive garment, QTY: 2 were non-certified on 5/8/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

[REDACTED] **Stimulator Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114,116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS for chronic pain, Page(s): 114-7.

**Decision rationale:** Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of a transcutaneous Electrotherapy Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. There are no documented short-term or long-term goals of treatment with the [REDACTED] Stimulator unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the Unit without previous failed TENS trial. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the therapy treatment already rendered. Additionally, a form-fitting stim device is only considered medically necessary with clear specific documentation for use of a large area that conventional system cannot accommodate or that the patient has specific medical conditions such as skin pathology that prevents use of traditional system that demonstrated in this situation. The [REDACTED] Stimulator Unit is not medically necessary and appropriate.

**Stimulator Supplies x monthsh Quantity 3: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS UNIT Page(s): 114, 116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS for chronic pain Page(s): 114-117.

**Decision rationale:** Since the primary service is not medically necessary, none of the associated services are medically necessary.

**Stimulator supplies (lead wires) x months Quantity 3: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS(Trancutaneous Electrical Nerve Stimulation) Unit Page(s): 114.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary service is not medically necessary, none of the associated services are medically necessary.

**Stimulator Supplies (batteries) x months Quantity 3: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS(Trancutaneous Electrical Nerve Stimulation) Unit Page(s): 114.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary service is not medically necessary, none of the associated services are medically necessary.

**Conductive garment for stimulator Quantity 2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS(Trancutaneous Electrical Nerve Stimulation) Unit Page(s): 114.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary service is not medically necessary, none of the associated services are medically necessary.