

Case Number:	CM14-0086991		
Date Assigned:	07/28/2014	Date of Injury:	07/29/2005
Decision Date:	08/28/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/10/2014

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 Medicine and is licensed to practice in Florida. 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 59-year-old female who reported an injury on 07/29/2005. The mechanism of injury was not provided within the medical records. The clinical note dated 06/26/2014 indicated diagnoses of depressive disorder and lumbar post laminectomy syndrome. The injured worker reported low back pain rated 7/10 and described as burning, cramping, electrical and shooting. The injured worker reported the pain radiated to her left leg and left toe in the right L5 distribution, left L5 distribution, bilateral S1 distribution and the left hip. The injured worker reported increased pain since last appointment due to increased physical activity. The injured worker reported left lower extremity weakness and numbness in the left lower extremity with tingling in the left lower extremity. The injured worker reported an interference with sleep. The injured worker reported factors that aggravated her pain were bending, walking, and weather change. Factors that alleviated the pain were exercise, heat, medication, position change, and rest. The injured worker reported she had attended a physical therapy evaluation and the first appointment. On physical exam of the lumbar spine, straight leg raise seated test was positive on both sides. There was tenderness over the lumbar spine bilaterally. The injured worker's prior treatments included diagnostic imaging, surgery, physical therapy, medication management. The injured worker's medication regimen included Flector patch, Motrin, tizanidine, and zolpidem. The provider submitted a request for TENS supplies x6 months. A request for authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS supplies x 6 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines - Transcutaneous Electrophotherapy.

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

Decision rationale: The California MTUS guidelines regarding Transcutaneous Electrical Nerve Stimulation (TENS) unit requires, "Chronic intractable pain documentation of at least a three month duration. There needs to be evidence that other appropriate pain modalities have been tried (including medication) and failed. 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; rental would be preferred over purchase during this trial. Other ongoing pain treatment should also be documented during the trial period including medication usage. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. Form-fitting TENS device: This is only considered medically necessary when there is documentation that there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment, that the patient has medical conditions (such as skin pathology) that prevents the use of the traditional system, or the TENS unit is to be used under a cast (as in treatment for disuse atrophy)." The documentation submitted did not indicate the injured worker was utilizing a TENS unit. In addition, the provider did not indicate a rationale for the request. Moreover, there was a lack of evidence that appropriate pain modalities had been tried prior to this request and there was a lack of evidence of a 1 month trial period of a TENS unit. It was also not indicated if the injured worker needed a 4-lead unit or a 2-lead unit. The request is considered not medically necessary.