

Case Number:	CM14-0092510		
Date Assigned:	07/25/2014	Date of Injury:	10/15/2013
Decision Date:	09/12/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	06/18/2014

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 female who reported an injury on 10/15/2013. The mechanism of injury was noted to be a fall. The diagnosis was noted to be a double fracture of the left cubitus and radius. Treatments included medications of ibuprofen and Norco. Additional therapy included hand therapy. Diagnostics included an x-ray. The primary treating physician's progress report on 06/02/2014 noted the injured worker with subjective complaints of left hand and wrist pain. She rated pain at a 6/10. The objective findings were noted to be the left upper extremity with a lateral deformity, partially reduced Colles' fracture. The left wrist appeared swollen. The left palm appeared to have fibrosis, complete with Dupuytren's contracture. She was unable to make a left fist. The treatment plan included hand therapy and wrist orthopedic evaluation, as well as medications, an x-ray and an MRI review. The provider's request was noted within the primary treating physician's progress report. A Request for Authorization form was not noted within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS Unit (purchase) on dos 05/21/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend a transcutaneous electrical nerve stimulation unit 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 an evidence based functional restoration program. Nor does it request a 1 month trial. As such, the request for TENS unit purchase on date of service 05/21/2014 is not medically necessary.