

Case Number:	CM14-0164891		
Date Assigned:	10/09/2014	Date of Injury:	12/09/2004
Decision Date:	01/26/2015	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/07/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 is a 59 year old patient with date of injury of 12/9/04. Medical records indicate the patient is undergoing treatment for s/p right knee arthroscopic in 2005, lumbar disease, radiculopathy, facet syndrome, synovial cyst at the lumbar facet and bilateral knee internal derangement. Subjective complaints include back pain radiating to bilateral legs down to feet with numbness and tingling in toes, worse on the right with pain rated 8/10. Persistent right knee symptoms as result of compensatory overuse, left knee pain since 2005. Objective findings include antalgic gait, diffuse tenderness of paravertebral musculature and moderate facet tenderness from L4 to S1; Kemp's, seated straight leg raise bilaterally, supine straight leg raise bilaterally and Farfan bilaterally were all positive. The patient's lumbar spine flexion and extension were at 60 degrees and right and left lateral bending 15. Sensation decreased along bilateral L4 and L5 dermatomes. Right knee pain/tenderness noted, bilateral knee range of motion noted 0 -135, patellar compression positive bilaterally, McMurray positive on left. MRI lumbar spine (unknown date) revealed multilevel degenerative disc disease, greatest at L3-L4 through L5-S1. At L4-L5 there is a 5 mm central /left paracentral disc protrusion with moderate bilateral facet arthropathy resulting in moderate spinal canal stenosis and moderate to severe bilateral neural foraminal narrowing and impingement of the bilateral transiting L5 and exiting L4 nerve roots. At L5-S1, there was severe bilateral facet arthropathy and a 2x1x1.5 cm synovial cyst at the right L5-S1 facet. There was also moderate left and mild right neural foraminal narrowing at this level. X-ray of bilateral knees dated 04/16/2014 severe bilateral medical joint degenerative disease, right side worse than the left and moderate bilateral joint degenerative disease. Treatment has consisted of physical therapy, chiropractic sessions, home exercise program, Tylenol #3 and bracing of the right knee. The utilization review determination was rendered on 10/1/14 recommending non-certification of Interferential Unit-30 days, trial home use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Unit-30 days, trial home use: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy. Page(s): 54, 114-116, 118 and. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, TENS chronic pain (transcutaneous electrical nerve stimulation).

Decision rationale: MTUS states regarding TENs unit, "Not recommended as a primary treatment modality, but a one-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, for the conditions described below." For pain, MTUS and ODG recommend TENS (with caveats) for neuropathic pain, phantom limb pain and CRPSII, spasticity, and multiple sclerosis. The medical records do not indicate any of the previous conditions. ODG further outlines recommendations for specific body parts: Low back: Not recommended as an isolated intervention Knee: Recommended as an option for osteoarthritis as adjunct treatment to a therapeutic exercise program Neck: Not recommended as a primary treatment modality for use in whiplash-associated disorders, acute mechanical neck disease or chronic neck disorders with radicular findings Ankle and foot: Not recommended Elbow: Not recommended Forearm, Wrist and Hand: Not recommended Shoulder: Recommended for post-stroke rehabilitation Medical records do indicate conditions of the low back and knee. ODG further details criteria for the use of TENS for Chronic intractable pain (for the conditions noted above): (1) Documentation of pain of at least three months duration (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed (3) 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 (4) Other ongoing pain treatment should also be documented during the trial period including medication usage (5) A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted (6) After a successful 1-month trial, continued TENS treatment may be recommended if the physician documents that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. At this point purchase would be preferred over rental. (7) Use for acute pain (less than three months duration) other than post-operative pain is not recommended. (8) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. The treating physician documents a trial and failure of conservative therapy, ongoing HEP and manual therapy. The treating physician has met the above guidelines. As such, the request for Interferential Unit-30 days, trial home use is medically necessary.