MAXIMUS Federal Services

Case Number:	CM15-0007087		
Date Assigned:	01/29/2015	Date of Injury:	06/20/2014
Decision Date:	03/24/2015	UR Denial Date:	12/16/2014
Priority:	Standard	Application Received:	01/13/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 24 year old male was injured on 6/20/14 in an industrial accident. That involved heavy lifting sustaining low back injury. Currently the injured worker complains of constant, burning, radicular low back pain that radiates to the bilateral lower extremities and muscle spasms. He rates his pain 6/10. His activities of daily living are compromised such as getting dressed and personal hygiene. Currently he takes deprizine, dicopanol, fanatrex, synapryn, tabradil, cyclobenzaprine and ketoprofen. Medications offer temporary relief. Diagnoses are lumbar spine sprain/ strain rule out herniated nucleus propulsus; rule out radiculitis lower extremities and sleep disorder. Treatments include physical therapy, acupuncture and shockwave therapy. Diagnostics include MRI lumbar spine. The treating physician requested transcutaneous electrical nerve stimulator unit. On 12/16/14 Utilization Review non-certified the request for transcutaneous electrical nerve stimulator unit citing MTUS: Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

INF TENS unit, purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for TENS Page(s): 114-116.

Decision rationale: The 24 year old patient presents with burning, radicular low back pain, rated at 6/10, along with numbness and tingling in bilateral lower extremities, as per progress report dated 11/19/14. The request is for INF TENS UNIT, PURCHASE. The RFA for the case is dated 09/30/14, and the patient's date of injury is 06/20/14. The patient's diagnoses, as per progress report dated 11/19/14, included lumbar spine sprain/strain, r/o lower extremity radiculitis, and sleep disorder. MRI of the lumbar spine, dated 10/10/14, revealed disc herniations at L2-3 and L4-5 along spinal canal and bilateral neural foraminal narrowing at L4-5 as Schmorl's node at L2. The patient is off work, and is temporarily totally disabled, as per progress report dated 11/19/14. For TENS unit, MTUS guidelines, on page 116, require (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) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. Criteria for Use of TENS Unit on page 116 and state that "There is evidence that other appropriate pain modalities have been tried (including medication) and failed. Also, the recommended trial period is for only 30 days.In this case, the patient does suffer from chronic low back pain. He has received conservative care in form of medications, physical therapy and shockwave therapy. While medications and activity reduction provide temporary relief, as per progress report dated 11/19/14, the impact of other treatment modalities is not known. The treater requests for a purchase of the TENS unit in progress report dated 09/10/14 but does not discuss the purpose of the request. Additionally, there is no documentation of prior one-moth trial and its outcome, and there is no treatment plan with short- and long-term goals. Hence, this request IS NOT medically necessary.