

<b>Case Number:</b>	CM15-0100583		
<b>Date Assigned:</b>	06/03/2015	<b>Date of Injury:</b>	09/14/2007
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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:

The injured worker is a 68-year-old male with an industrial injury dated 02/12/2007 and 09/14/2007. His diagnoses included bilateral knee tendinopathy and chondromalacia with early arthrosis, multi-level cervical and lumbar discopathy and chronic pain syndrome. Co morbid diagnoses included glaucoma and treated prostate cancer. Prior treatment included TENS unit, medication and psychological evaluation. He presented on 04/08/2015 with ongoing chronic aching pain to his neck, low back, headaches, pain in bilateral shoulders, elbows, hands/wrists, bilateral knees and bilateral feet/ankles with numbness and pins and needles sensation. Physical exam of the lumbar spine revealed tenderness, spasm and tightness with reduced range of motion. There was mild decreased lumbar range of motion. The treating physician notes the injured worker's TENS unit had been out of commission for two to three months and since then his pain level had increased. The TENS unit helped him to minimize oral medicines and increase daily function. Treatment plan included durable medical equipment of Pro Stim unit, TENS unit and cane. The treatment request is for durable medical equipment: Pro-Stim unit 5.0, cane and transcutaneous electrical nerve stimulation (TENS) unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Durable medical equipment (DME) transcutaneous electrical nerve stimulation (TENS)/interferential (if) unit (new): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 235, 300, Chronic Pain Treatment Guidelines Page(s): 75.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain, pages 114-117.

**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 TENS 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. From the submitted reports, the patient has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive physical therapy, activity modifications, yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, whether this is for rental or purchase, nor is there any documented short-term or long-term goals of treatment with the TENS unit. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the treatment already rendered. The Durable medical equipment (DME) transcutaneous electrical nerve stimulation (TENS)/interferential (if) unit (new) is not medically necessary and appropriate.

**Durable medical equipment (DME) Pro-Stim unit 5.0: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain, pages 114-117.

**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 is no documented short-term or long-term goals of treatment with the OrthoStim 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 OrthoStim Unit without specified rental or purchase request or 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 physical therapy treatment already rendered. The Durable medical equipment (DME) Pro-Stim unit 5.0 is not medically necessary and appropriate.

**Durable medical equipment (DME) cane:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee Chapter, Walking aids (canes, crutches, braces, orthoses, & walkers), page 358-359.

**Decision rationale:** The injured worker has diagnoses to include bilateral knee tendinopathy and chondromalacia with early arthrosis, multi-level cervical and lumbar discopathy and chronic pain syndrome. Co-morbid diagnoses also included glaucoma and treated prostate cancer. ODG guidelines note contra lateral cane placement is the most efficacious for persons with knee osteoarthritis, whereby, no cane use may be preferable to ipsilateral cane usage as the latter resulted in the highest knee moments of force, a situation which may exacerbate pain and deformity. Per review, the utilization report dated 5/5/15 had authorization of this request; thereby, the Durable medical equipment (DME) cane is medically necessary and appropriate.