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| Case Number: | CM15-0143556 | | |
| Date Assigned: | 08/04/2015 | Date of Injury: | 07/21/2014 |
| Decision Date: | 09/02/2015 | UR Denial Date: | 06/19/2015 |
| Priority: | Standard | Application Received: | 07/23/2015 |

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, Pain Management

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 55 year old female, who sustained an industrial injury on 7-21-2014. She reported a fall, landing on her buttocks. The injured worker was diagnosed as having sprain of lateral collateral ligament of knee. Treatment to date has included diagnostics, left knee injection, physical therapy, chiropractic, acupuncture, and medications. The Doctor's First Report of Occupational Injury or Illness (1-24-2015) noted complaints of left knee pain and stiffness, lumbar spine stiffness and pain, right arm pain and weakness, left leg soreness, and left foot stiffness. The treatment plan at that time included a transcutaneous electrical nerve stimulation unit rental. Updated progress reports to support the continued use of a four lead transcutaneous electrical nerve stimulation unit beginning 4-20-2015 were not noted. The PR2 dated 5-27-2015 did not include subjective complaints or objective findings. Use of a transcutaneous electrical nerve stimulation unit was not referenced.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: TENS Four Lead (DOS) 04/20/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117 of 127.

Decision rationale: Regarding the request for TENS, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is 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. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial 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, function, and medication usage. Within the documentation available for review, there is no indication that the patient has undergone a one-month TENS unit trial as outlined above and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested TENS is not medically necessary.