

Case Number:	CM15-0160332		
Date Assigned:	08/26/2015	Date of Injury:	03/11/2014
Decision Date:	09/29/2015	UR Denial Date:	07/20/2015
Priority:	Standard	Application Received:	08/17/2015

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 45 year old female who sustained an industrial injury on March 11, 2014. A doctors' first report of illness date November 20, 2014 reported while working pushing an object she sustained an inguinal hernia on the left side requiring surgical intervention. She is not post-operative and with pain. There was recommendation for pain management consultation. There is noted subjective complaint of left lower quadrant abdominal pain. She is taking Naproxen and Tramadol as needed. She is diagnosed with having residual pain post inguinal hernia repair, left with no evidence of recurrence on ultra sound. The plan of care noted prescribing Ketoprofen gel 20% along with a transcutaneous nerve stimulator for home use and training by physical therapy. She is to return to a modified work duty. A primary treating follow up dated May 27, 2015 reported chief complaint of left lower abdominal pain and an aggravation of lower back pain with intermittent left lower extremity pain. She reports the pain is causing sleep issue, emotional, financial and marital concerns. Previous treatment modality to include: activity modification, oral medications, physical therapy, acupuncture, injections, surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transcutaneous nerve stimulator for home use (purchase): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, (transcutaneous electrical nerve stimulation).

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

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 and function. Within the documentation available for review, there is no indication that the patient has undergone a TENS unit trial, and no documentation of any specific objective functional deficits which a tens unit trial would be intended to address. In the absence of clarity regarding those issues, the currently requested TENS unit is not medically necessary.