

Case Number:	CM15-0187713		
Date Assigned:	09/29/2015	Date of Injury:	07/16/2009
Decision Date:	11/09/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/24/2015

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: Emergency Medicine

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 60 year old female who sustained an industrial injury on 07-16-2009. Current diagnoses include low back pain, cervical spine surgery, and lumbar spine surgery. Report dated 07-22-2015 noted that the injured worker presented with complaints that included lower back pain with occasional leg pain as well as numbness and tingling both legs and feet. Other complaints include moderate neck pain with radiation to the right shoulder and down the right arm. It was documented that the injured worker was provided an H-wave unit by the physical therapist. Physical examination performed on 07-22-2015 revealed restricted cervical range of motion, mild to moderate tenderness in the cervical spine and right trapezius, and mild tenderness over the nerve roots on both sides, decreased lumbar range of motion, tenderness over the lumbosacral junction, paraspinal muscles, sacroiliac joints, sacrum, coccyx, and sciatic nerves on both sides. Previous treatments included medications, surgical interventions, and physical therapy. The treatment plan included additional postoperative physical therapy, written prescriptions were given, and re-evaluation in 7 weeks. The utilization review dated 09-08-2015, non-certified/modified the request for home TENS device.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home TENS (transcutaneous electrical nerve stimulation) device: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: As per MTUS Chronic pain guidelines, TENS (Transcutaneous Electrical Nerve Stimulation) may be recommended only if it meets criteria. Evidence for its efficacy is poor. Pt does not meet criteria to recommend TENS. Guidelines recommend use only with Functional Restoration program, which is not documented. There is no documentation of short or long-term goal of TENS unit. There is no documentation of an appropriate 1-month trial of TENS. Patient fails multiple criteria for TENS purchase. TENS is not medically necessary.