

Case Number:	CM15-0197740		
Date Assigned:	10/13/2015	Date of Injury:	10/01/1993
Decision Date:	11/20/2015	UR Denial Date:	09/23/2015
Priority:	Standard	Application Received:	10/08/2015

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: New York

Certification(s)/Specialty: Internal 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 58 year old male who sustained an industrial injury on 10-1-93. The injured worker reported back and leg pain. A review of the medical records indicates that the injured worker is undergoing treatments for lumbar radiculitis, low back and left leg pain, lumbar spondylosis, chronic pain syndrome and muscle spasm of the back . Medical records dated 9-29-15 indicate pain rated at 5 to 6 out of 10. Provider documentation dated 9-29-15 noted the work status as retired. Treatment has included lumbar spine magnetic resonance imaging, transcutaneous electrical nerve stimulation unit, physical therapy, Lyrica since at least June of 2015, Ibuprofen since at least June of 2015, Tramadol since at least June of 2015, Lidoderm Patch since at least June of 2015, Norco, lumbar spine radiographic studies. Physical examination dated 9-19-15 was notable for tenderness to lumbosacral spine with decreased range of motion, straight leg raise positive on the left. The original utilization review (9-23-15) denied a request for 1 TENS unit and Associated service: 1 TENS supplies.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 TENS unit: 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: According to the MTUS guidelines, the TENS unit is not recommended as a primary treatment modality. A one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for conditions such as, neuropathic pain, phantom limb pain, complex regional pain syndrome (CRPS), spasticity or multiple sclerosis (MS). In this case, the patient has used a TENS unit and there is no documentation of any functional benefit from the TENS unit He reported only a 40-50% decrease in pain. Medical necessity for the requested item is not established. The requested TENS Unit is not medically necessary.

Associated service: 1 TENS supplies: 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: The requested TENS is not medically necessary. There is no indication for any of the requested TENS supplies. Medical necessity for the requested items is not established. The requested items are not medically necessary.