MAXIMUS Federal Services

Case Number:	CM15-0030151		
Date Assigned:	02/23/2015	Date of Injury:	07/18/2010
Decision Date:	04/07/2015	UR Denial Date:	02/03/2015
Priority:	Standard	Application Received:	02/18/2015

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 Jersey, Michigan, California
Certification(s)/Specialty: Neurology, Neuromuscular 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 53 year old male who sustained a work related injury on July 18, 2010. He was struck on the head by a car mirror, knocked down and suffered multiple injuries. He was diagnosed with a closed head injury, scalp laceration, lumbar sprain, neck pain and right wrist fracture. Treatment included physical therapy, massage therapy, epidural steroid injections, acupuncture treatment, anti-inflammatory drugs, and pain medications. He underwent a left shoulder repair and distal clavicle resection.Currently, the injured worker complained of increased back pain with radiation to the right buttock and into the knee, headaches, mid back and left shoulder pain. Treatment had included massage therapy and acupuncture.On February 28, 2015, a request for a purchase of a Transcutaneous Electrical Nerve Stimulation (TENS) Unit was non-certified by Utilization Review, noting the California Medical Treatment Utilization Schedule Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS (Transcutaneous electrotherapy) Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous Electrical Nerve Stimulation Page(s): 97.

Decision rationale: According to MUTUS guidelines, TENS is not recommended as primary treatment modality, but a one month based trial may be considered, if used as an adjunct to a functional restoration program. There is no evidence that a functional restoration program is planned for this patient. Furthermore, there is no clear information about a positive one month trial of TENS. There is no recent documentation of recent flare of his pain. The provider should document how TENS will improve the functional status and the patient's pain condition. Therefore, the prescription of TENS unit is not medically necessary.