MAXIMUS Federal Services

Case Number:	CM15-0031199		
Date Assigned:	02/24/2015	Date of Injury:	12/27/1998
Decision Date:	04/07/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	02/19/2015

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 40 year old female, who sustained an industrial injury on 12/27/1998. The mechanism of injury was not noted. The diagnoses have included lumbosacral spondylosis. Treatment to date has included surgical (multiple spinal) and conservative measures. On 12/30/2014, the injured worker complained of neck and low back pain, rated 7/10. She reported radicular symptoms from the low back into her bilateral feet. Current medications included Fentanyl, Oxycodone, Soma, Lyrica, oral Voltaren, and Lidoderm. Medications were reported to only moderately control pain. In the previous three months, the injured worker was documented as developing balance and ambulation problems. Physical exam of the cervical spine noted paraspinous muscle spasm, decreased range of motion with flexion and extension, and positive bilateral facet loading maneuvers. Exam of the lumbar spine noted moderate tenderness at the bilateral paraspinals, moderately decreased range of motion, positive FABER's bilateral, and positive bilateral provocation test. Straight leg raise test was positive bilaterally. Decreased sensation in the left lower extremity was noted, L5-S1. Treatment plan included a home transcutaneous electrical nerve stimulation unit. On 1/22/2015, Utilization Review non-certified a request for 1 transcutaneous electrical nerve stimulation unit, noting the lack of compliance with MTUS Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

One transcutaneous electrical nerve stimulation (TENS) unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114.

Decision rationale: According to MTUS 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. There is no recent documentation of recent flare of neuropathic pain. There is no strong evidence supporting the benefit of TENS for neck, shoulder and wrist disorders. Therefore, the prescription of Retrospective TENS is not medically necessary.