

Case Number:	CM15-0033066		
Date Assigned:	02/26/2015	Date of Injury:	08/26/2008
Decision Date:	04/13/2015	UR Denial Date:	02/11/2015
Priority:	Standard	Application Received:	02/23/2015

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 female who sustained a work related injury on August 26, 2008, incurring injuries to the neck and low back. She was diagnosed with cervical discopathy with radiculitis, lumbar discopathy with radiculitis, bilateral knee internal derangement, bilateral ankles internal derangement and right greater trochanteric bursitis. She underwent lumbar spine hardware removal, left knee surgery and right knee surgery. Treatment included physical therapy, aquatic therapy, epidural steroid injections, and medications. Currently, the injured worker complained of persistent neck and shoulder pain radiating into the upper extremities, spinal pain and right knee pain. On February 11, 2015, a request for Electrode Gel 2 PR Sensaderm lead, 4 pack, 2 red/2 black from date of service January 9, 2015; Battery alkaline 9.0 volt from date of service January 9, 2015; and Adhesive remove wipe from date of service January 9, 2015, was non-certified by Utilization Review, noting the California Medical Treatment Utilization Schedule Guidelines 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:

Retrospective: Electrode gel 2 PR Sensaderm lead, 4/pkg 2red/2 blk (DOS 1/09/2015):
 Upheld

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

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. Efficacy should be documented prior to the use of a home unit. The provider should document how TENS will improve the functional status and the patient's pain condition. Therefore, the TENS unit is not medically necessary. Subsequently, the retrospective request for Retrospective: Electrode gel 2 PR Sensaderm lead, 4/pkg 2red/2 blk is not medically necessary.

Retrospective: Battery alkaline 9.0 v (DOS 1/09/2015): Upheld

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

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. Efficacy should be documented prior to the use of a home unit. The provider should document how TENS will improve the functional status and the patient's pain condition. Therefore, the TENS unit is not medically necessary. Subsequently, the retrospective request of Battery alkaline 9.0 v is not certified.

Retrospective: Adhesive remove wipe (DOS 1/09/2015): Upheld

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

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. Efficacy should be documented prior to the use of a home unit. The provider should document how TENS will improve the functional status and the patient's pain condition.

Therefore, the TENS unit is not medically necessary. Subsequently, the retrospective request for Adhesive remove wipe is not medically necessary.