

Case Number:	CM15-0042372		
Date Assigned:	03/12/2015	Date of Injury:	06/17/2009
Decision Date:	04/23/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/06/2015

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, New York

Certification(s)/Specialty: Family Practice

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 64 year old female, who sustained an industrial injury on June 17, 2009. The injured worker had reported a right shoulder, right hand and bilateral knee injuries. The diagnoses have included chronic pain syndrome, status post left total knee replacement, right shoulder tendonitis, right shoulder impingement and rotator cuff tear, right elbow lateral epicondylitis, right elbow surgery, right carpal tunnel syndrome and lumbar herniated discs with radiculopathy. Treatment to date has included medications, physical therapy, a left knee open reduction and internal fixation in 2009 and a left total knee replacement in 2013. Current documentation dated February 11, 2015 notes that the injured worker reported low back pain with radiation into the bilateral lower extremities. Physical examination of the lumbar spine revealed tenderness and a decreased range of motion. Tightness and spasms of the paraspinal musculature bilaterally was also noted. A straight leg raise test was positive bilaterally. The treating physician's plan of care included a request for a dual electrical nerve/muscle stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dual electrical nerve and muscle stimulator (TENS-EMS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Transcutaneous electrotherapy Page(s): (s) 114-116.

Decision rationale: The request for a TENS/EMS unit is not medically necessary. The criteria for use of a TENS unit includes evidence of failed pain modalities including medication. The chart does not document failure of all conservative measures. A one-month trial of the TENS unit should also be documented. There was no documentation of a trial and there are no MTUS guidelines for use of a TENS/EMS combination device. Treatment plan with short and longer term goals was not documented as well. Therefore, it is considered not medically necessary.