

Case Number:	CM14-0173116		
Date Assigned:	10/23/2014	Date of Injury:	06/14/2010
Decision Date:	12/02/2014	UR Denial Date:	09/23/2014
Priority:	Standard	Application Received:	10/20/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant is a 60 year old male who sustained a work injury on 6-14-10. The claimant has a diagnosis of low back pain. He has been treated with physical therapy, epidural steroid injection and medications. Office visit on 9-5-14 notes the claimant has pain rated as 8/10 without medications and 4/10 with medications. On exam, the claimant has an antalgic gait that is slow and stopped. He has restricted range of motion, hypertonicity, and tenderness with taut muscle bands, positive facet loading and Fabere's test. He has 5-/5 strength in bilateral EHL and knee extensors and patchy sensation.

IMR ISSUES, DECISIONS AND RATIONALES

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

GSM HD Combo with HAN, Purchase with Electrodes x 8 and Batteries x 6 for 1 month.:
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): 114-117. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter - TENS

Decision rationale: Chronic Pain Medical Treatment Guidelines as well as ODG notes that a TENS unit is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. This modality is recommended for conditions such as spasticity, multiple sclerosis, neuropathic pain, phantom limb pain. There is an absence in documentation noting that this claimant has had a trial with daily pain diaries noting functional and documented improvement. There is an absence in documentation he has any of these conditions for which a one month trial would be considered. Therefore, the medical necessity of this request is not established.