

Case Number:	CM14-0212829		
Date Assigned:	12/30/2014	Date of Injury:	10/14/2010
Decision Date:	02/27/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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: Arizona, California, Florida
 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 57-year-old female who reported injury on 05/19/2010. The mechanism of injury was not submitted for review. The injured worker has diagnoses of lumbar spine sprain/strain with bilateral lower extremity radiculopathy, facet joint osteoarthritis. It was noted that the injured worker had facet joint osteoarthritis on an MRI that was obtained in 09/2011. MRI was not submitted for review. On 05/08/2014, the injured worker complained of lumbar spine pain. Described the pain as moderate and constant. There was weakness. There was tenderness to palpation in the lumbar spine with spasm. A negative straight leg raise. Positive Kemp's. There was flexion of 35 degrees, extension of 10 degrees, right bending of 15 degrees and left bending to 15 degrees. Sensory motor was intact. Deep tendon reflexes were +2 bilaterally. Past medical treatment consists of the use of a TENS unit and medication therapy. Medications include Tylenol No.3 and Robaxin. Medical treatment plan is for the injured worker to continue with the use of a TENS unit and medication therapy. Rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy (TENs) Page(s): 116.

Decision rationale: The request for TENS unit rental is not medically necessary. The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A 1 month home based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of equal bilaterally functional restoration. The results of studies are inconclusive; the published trials do not provide information on the stimulation parameters, which are most likely to provide optimum pain relief, nor do they answer questions about long term effectiveness. The efficacy of the injured worker's previous course of conservative care was not provided. Furthermore, it was indicated that the injured worker has been using the TENS unit. There was no indication of the efficacy of the use of the machine, nor did it indicate as to how long the injured worker has been using the TENS unit. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.

DME: Electrodes with refill of supplies, batteries, wipes (Purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.