MAXIMUS Federal Services

Case Number:	CM15-0015221		
Date Assigned:	02/03/2015	Date of Injury:	10/05/2011
Decision Date:	03/20/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	01/27/2015

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 51 year old male who sustained an industrial injury to his neck and shoulder on October 5, 2011. The injured worker was diagnosed with cervical degenerative disc disease with radiculopathy, low back pain, left shoulder and left wrist pain. There were no surgical interventions noted. The injured worker had conservative treatment and medication. He continued to experience neck, shoulder and low back pain. According to the primary treating physician's progress report on November 11, 2014 an magnetic resonance imaging (MRI) of the lumbar spine (date not documented) demonstrated a right paracentral disk herniation with annular tear at L5-S1 which deviates the S1 nerve and lateral recess and mild facet joint degenerative changes at L5-S1. Magnetic resonance imaging (MRI) of the right shoulder demonstrated SLAP lesion, adhesive capsulitis and severe supraspinatus tendinosis. Current medications are listed as Norco, Tylenol Extra Strength, Naproxen, Ambien, Biofreeze topical analgesic and Prilosec. Treatment modalities consisted of physical therapy, epidural steroid injection (ESI), psychological evaluation and medications.The treating physician requested authorization for Retrospective request for one month rental transcutaneous electrical nerve stimulation (TEN's) unit, DOS: 11-22-14 to 12-1-14.On January 14, 2015 the Utilization Review denied certification for the Retrospective request for one month rental transcutaneous electrical nerve stimulation (TEN's) unit, DOS: 11-22-14 to 12-1-14. Citations used in the decision process were the Medical Treatment Utilization Schedule (MTUS), Chronic Pain Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for One month rental TENS unit, DOS 11/22/14-12-1-14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain, pages 114-117.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, the patient has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive physical therapy, activity modifications, yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, nor is there any documented short-term or long-term goals of treatment with the TENS unit. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the treatment already rendered. The Retrospective request for One month rental TENS unit, DOS 11/22/14-12/1/14 is not medically necessary and appropriate.