MAXIMUS Federal Services

Case Number:	CM15-0114665		
Date Assigned:	06/22/2015	Date of Injury:	04/21/2000
Decision Date:	07/22/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	06/15/2015

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 62 year old female, who sustained an industrial injury on 4/21/00. The diagnoses have included lumbar spine pain; lumbar spine radiculopathy; lumbar spine sprain and right knee degenerative joint disease. Treatment to date has included cyclobenzaprine for muscle spasm; naproxen to reduce inflammation and omeprazole to protect the stomach against other medications. The injured worker has complaints of bilateral wrists/hands pain right greater than left and complaints of lumbar spine and right knee pain. The documentation noted that the injured worker had low back pain travelling through her right leg to her right foot with associated paresthesia in the toes of her right foot. The documentation noted on examination of the bilateral wrists/hands there is mild tenderness and swelling in the bilateral hands and decreased grip strength. Lumbar spine had tenderness to palpation associated with myospasms and limited range of motion. Right knee palpable tenderness is elicited about the medial joint line and range of motion is restricted with crepitus. The request was for transcutaneous electrical nerve stimulation unit for home use for the lumbar, right knee, and right wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit for home use for the lumbar, right knee, and right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

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, whether this is for rental or purchase for home use, 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 TENS unit for home use for the lumbar, right knee, and right wrist is not medically necessary or appropriate.