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| Case Number: | CM15-0125700 | | |
| Date Assigned: | 07/10/2015 | Date of Injury: | 10/14/2000 |
| Decision Date: | 08/06/2015 | UR Denial Date: | 05/29/2015 |
| Priority: | Standard | Application Received: | 06/29/2015 |

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: North Carolina

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 75-year-old male who sustained an industrial injury on 10/14/00. Per Utilization review the injured worker was hit by a pressure hose that lacerated his leg. In addition he suffered a back injury while in the work hardening program. There were no subjective or objective findings noted in the information available for review. Medication was naproxen. Diagnoses include L4-L5 mm disc herniation with facet arthropathy resulting in moderate spinal stenosis; probable right sided radiculopathy; left knee patella tendon laceration, status post repair; sleep apnea and multiple non-industrial medical issues. Treatments to date include medications; left knee Supartz injection X3; pain management. There were no notes regarding efficacy of injections. Diagnostics include MRI of the lumbar spine (4/2/15) showing spinal stenosis, neuroforaminal stenosis, disc protrusion. On 5/29/15, Utilization Review evaluated the request for transcutaneous electrical nerve stimulator unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS (transcutaneous electrical nerve stimulation) Unit Supplies, Pads, Batteries, Leads:
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 TENS
Page(s): 114.

Decision rationale: The California chronic pain medical treatment guidelines section on transcutaneous electrical nerve stimulation states: TENS, chronic pain (transcutaneous electrical nerve stimulation). 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, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, 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. (Carroll-Cochrane, 2001) Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. One problem with current studies is that many only evaluated single dose treatment, which may not reflect the use of this modality in a clinical setting. Other problems include statistical methodology, small sample size, influence of placebo effect, and difficulty comparing the different outcomes that were measured. This treatment option is recommended as an adjunct to a program of evidence based functional restoration. However, it is recommended for a one-month trial to document subjective and objective gains from the treatment. There is no provided documentation of a one-month trial period with objective measurements of improvement. Therefore criteria have not been met and the request is not medically necessary.