MAXIMUS Federal Services

Case Number:	CM15-0041049		
Date Assigned:	03/11/2015	Date of Injury:	09/09/2008
Decision Date:	06/22/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	03/04/2015

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: Massachusetts
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 65-year-old female with an industrial injury dated 9/09/2008. The injured worker's diagnoses include lumbosacral sprain/strain, piriformis syndrome, thoracic sprain/strain and myofascial pain. Treatment consisted of diagnostic studies, prescribed medications, ice therapy, home exercise therapy and periodic follow up visits. In a progress note dated 12/18/2014, the injured worker reported low back pain, frequently radiating to bilateral hips/gluteus/groin with tightness, bilateral lower extremity (right greater than left) with numbness/tingling to bilateral feet, and occasional radiation to the mid back. The injured worker rated pain a 5/10 with treatment consisting of medication, ice therapy and home exercises. The injured worker rated pain a 7-8/10 without treatment. Objective findings revealed antalgic gait and ambulation with a roller. The treating physician prescribed services for transcutaneous electrical nerve stimulation (TENS) unit for permanent home use now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS Unit for permanent home use: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

Decision rationale: The claimant sustained a work-related injury in September 2008 and continues to be treated for radiating low back pain. When seen, pain was rated at 7/10. There was decreased lumbar range of motion with tenderness and muscle spasms. There was sacroiliac joint and piriformis muscle tenderness with increased leg pain. Criteria for the use of TENS include that there is documentation of a one-month trial period of the TENS unit including how often the unit was used, as well as outcomes in terms of pain relief. Since no documented trial of TENS was submitted with the records provided for this review, the medical necessity of purchasing a TENS unit for permanent home use is not medically necessary.