MAXIMUS Federal Services

Case Number:	CM15-0090094		
Date Assigned:	05/14/2015	Date of Injury:	04/05/2008
Decision Date:	06/22/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	05/11/2015

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 49-year-old female who sustained an industrial injury on 04/05/2008. The injured worker was diagnosed with displacement of lumbar intervertebral disc without myelopathy and chronic pain syndrome with right L5 and S1 radicular pain. The injured worker is status post L4-L5 and L5-S1 diskectomy in 2013. Treatment to date includes diagnostic testing, back surgery, physical therapy, pain management, transcutaneous electrical nerve stimulation (TEN's) unit and medications. According to the primary treating physician's progress report on April 16, 2015, the injured worker continues with low back pain radiating to the right leg, right anterior thigh, and calf and occasionally to the dorsum of the foot. The injured worker has had multiple emergency room visits due to recent flare-ups of pain. Examination demonstrated decreased sensation at left L5, motor L4-S1 intact and positive Faber's and Gower's test on the right, slight atrophy of right calf and limited range of motion. Current medications listed on April 13, 2015 are Oxycodone, Gabapentin, Flexeril, Skelaxin, Robaxin, Restoril and Duragesic patches increased from every 3 days to every 2 day. Dilaudid 4 mg four times a day was also added for 5 days for pain control. The injured worker received Toradol intramuscularly for low back pain aggravation on April 13, 2015. Treatment plan consists of lumbar spine and right hip X-rays, magnetic resonance imaging (MRI) of the lumbar spine, pain management follow-up, lumbar epidural steroid injection, acupuncture therapy, and the current request for replacement for a non-working transcutaneous electrical nerve stimulation (TEN's) unit for home use.

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: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tens.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 116.

Decision rationale: The patient presents with low back pain radiating to lower extremity. The request is for TENS UNIT FOR HOME USE. The request for authorization is dated 04/27/15. MRI of the lumbar spine, 04/2015, shows significant degenerative disc disease L4-S1, and possible retrolisthesis L4-5. X-rays of the lumbar spine, date unspecified, shows degenerative disc disease L4-S1, and positive sclerosis end plates. Physical examination of the lumbar spine reveals decreased sensation at left L5. Limited range of motion. Positive Lasegue's and Faber test on right. Positive Gower sign. Per progress report dated 04/16/15, the patient is permanent and stationary. According to MTUS Chronic Pain Management Guidelines the criteria for use of TENS in chronic intractable pain (p116) "a one month trial period of the TENS unit should be documented (as an adjunct to other treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function during this trial." Per progress report dated 04/16/15, treater's reason for the request is "TENS unit has helped previously, unit no longer functioning well." It appears this is a request for a replacement TENS unit to be used for the patient's low back pain. However, the patient does not present with a diagnosis indicated for the use of TENS. MTUS recommends TENS for neuropathic pain, CRPS, Multiple Sclerosis, Phantom pain, and spasticity pain. Furthermore, the treater does not indicate how the unit is being used, how often and with what effectiveness in terms of not only pain relief but of functional improvement. MTUS requires documentation of use of TENS, as an adjunct to other treatment modalities, within a functional restoration approach. This request is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.