

Case Number:	CM15-0096030		
Date Assigned:	05/26/2015	Date of Injury:	08/30/2012
Decision Date:	06/24/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	05/19/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 61-year-old male, who sustained an industrial injury on 8/30/12. The injured worker was diagnosed as being status post incision and drainage of the lumbar spine and status post laminectomy. Treatment to date has included TENS, chiropractic treatment, physical therapy, acupuncture, and medication. An electro myogram of bilateral lower extremities was noted to have revealed chronic radiculopathy. TENS and chiropractic treatment was noted to have been helpful in the past. Currently, the injured worker complains of low back pain with radiation to bilateral lower extremities. The treating physician requested authorization for a TENS unit for the spine and chiropractic treatment 2x4 for the lower back.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS Unit Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, TENS chronic pain (transcutaneous electrical nerve stimulation).

Decision rationale: MTUS states regarding TENS unit, "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." For pain, MTUS and ODG recommend TENS (with caveats) for neuropathic pain, phantom limb pain and CRPSII, spasticity, and multiple sclerosis. The medical records do not indicate any of the previous conditions. ODG further outlines recommendations for specific body parts: Low back: Not recommended as an isolated intervention. Knee: Recommended as an option for osteoarthritis as adjunct treatment to a therapeutic exercise program. Neck: Not recommended as a primary treatment modality for use in whiplash-associated disorders, acute mechanical neck disease or chronic neck disorders with radicular findings. Ankle and foot: Not recommended. Elbow: Not recommended. Forearm, Wrist and Hand: Not recommended. Shoulder: Recommended for post-stroke rehabilitation. Medical records do not indicate conditions of the low back, knee, neck, ankle, elbow, or shoulders that meet guidelines. Of note, medical records do not indicate knee osteoarthritis. ODG further details criteria for the use of TENS for Chronic intractable pain (for the conditions noted above): (1) Documentation of pain of at least three months duration. (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed. (3) A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing 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; rental would be preferred over purchase during this trial. (4) Other ongoing pain treatment should also be documented during the trial period including medication usage. (5) A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. (6) After a successful 1-month trial, continued TENS treatment may be recommended if the physician documents that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. At this point purchase would be preferred over rental. (7) Use for acute pain (less than three months duration) other than post-operative pain is not recommended. (8) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. The medical records do not satisfy the several criteria for selection specifically, lack of documented short-long term treatment goals with TENS unit, and unit use for acute (less than three months) pain. The treating physician notes that this patient has utilized a TENS unit in the past and has had pain relief, however, there is no documentation of objective functional improvement with prior use. Additionally, the treating physician notes that the patient's other TENS leads are not working, however it is not noted if there has been attempts to repair this unit. As such, the request for TENS Unit Spine is not medically necessary.

Chiropractic 2xWk x 4Wks for the lower back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Chiropractic, Manipulation.

Decision rationale: ODG recommends chiropractic treatment as an option for acute low back pain, but additionally clarifies that "medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated." Additionally, MTUS states "Low back: Recommended as an option. Therapeutic care: Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective /maintenance care: Not medically necessary. Recurrences/flare-ups: Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Medical documents indicate that patient has undergone and unknown number of previous chiropractic sessions. The treating provider has not demonstrated evidence of objective and measurable functional improvement with previous therapy to warrant continued treatment. As such, the request for Chiropractic 2xWk x 4Wks for the lower back is not medically necessary.