

<b>Case Number:</b>	CM15-0096470		
<b>Date Assigned:</b>	05/26/2015	<b>Date of Injury:</b>	12/01/2001
<b>Decision Date:</b>	08/06/2015	<b>UR Denial Date:</b>	04/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	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: 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 57 year old female who sustained an industrial injury on December 1, 2001. She has reported a right knee injury and has been diagnosed with status post left total knee arthroscopy and end stage osteoarthopathy, right knee. Treatment has included injections, surgery, medications, A TENS unit, and physical therapy. It is noted cyclobenzaprine does decrease spasm and facilitates improved range of motion. Tramadol does decrease pain and facilitates increased activity. There was tenderness to the right knee medial and lateral joint line. There was crepitation with range of motion assessment and no acute distress. It is well noted series of 3 viscosupplementation right knee facilitates approximate 60 % diminution in the right knee pain with improved tolerance to standing and walking. The treatment request included a TENS unit supplies and a stationary bicycle.

### 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:** Overturned

**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 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. Criteria have been met in the included documentation and therefore the request is medically necessary.

**Stationary Bicycle:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47. Decision based on Non-MTUS Citation Official Disability Guidelines: Durable Medical Equipment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) durable medical equipment.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested item. Per the Official Disability Guidelines section on durable medical equipment, DME is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. DME equipment is defined as equipment that can withstand repeated use i.e can be rented and used by successive patients, primarily serves a medical function and is appropriate for use in a patient's home. The equipment itself is not rentable or able to be used by successive patients. It does not serve a primary medical purpose that cannot be accomplished without it. Therefore criteria have not been met per the ODG and the request is not medically necessary.