

Case Number:	CM15-0098893		
Date Assigned:	06/01/2015	Date of Injury:	06/10/2013
Decision Date:	07/01/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/22/2015

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: Emergency 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 60 year old male, who sustained an industrial injury on 06/12/2013. He has reported subsequent neck, right upper extremity, right shoulder, right lower extremity, low back and right knee pain and was diagnosed with right greater trochanteric bursitis, right cervical radiculopathy with sensory loss, right shoulder impingement syndrome, right leg radiculopathy with weakness, L4-S1 stenosis and right knee lateral meniscus tear. Treatment to date has included oral pain medication, physical therapy, subacromial injection of the right shoulder and epidural steroid injections. In a progress note dated 03/31/2015, the injured worker complained of neck pain radiating down the bilateral shoulders, pain and numbness down the bilateral upper extremities, low back pain and numbness radiating down the bilateral lower extremities and bilateral knee pain. Objective findings were notable for decreased sensation over the left C6 dermatome distribution, decreased cervical range of motion, positive impingement sign of the shoulders bilaterally, an antalgic gait, decreased sensation over the left L3-S1 dermatome distribution, paresthesias to touch over the right lower extremity and positive straight leg raise on the right at 40 degrees. A request for authorization of TENS unit was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

Decision rationale: As per MTUS Chronic pain guidelines, TENS (Transcutaneous Electrical Nerve Stimulation) may be recommended only if it meets criteria. Evidence for its efficacy is poor. Pt does not meet criteria to recommend TENS. TENS is only recommended for neuropathic or Complex Regional Pain Syndrome (CRPS) pain. Patient has a diagnosis of radicular pain. There is no documentation of failures of multiple conservative treatment modalities. Guidelines recommend use only with Functional Restoration program, which is not documented. There is no documentation of short or long-term goal of TENS unit. There is no documentation of an appropriate 1-month trial of TENS. Patient fails multiple criteria for TENS. TENS is not medically necessary.