

<b>Case Number:</b>	CM13-0029489		
<b>Date Assigned:</b>	11/01/2013	<b>Date of Injury:</b>	01/11/2013
<b>Decision Date:</b>	01/17/2014	<b>UR Denial Date:</b>	09/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and Pain Medicine and is licensed to practice in Oklahoma and Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 54-year-old male who reported an injury on 01/11/2013. The patient is currently diagnosed with a rotator cuff tear of the right shoulder, cubital tunnel syndrome of the right forearm, and status post lumbar fusion. The patient was seen by [REDACTED] on 08/28/2013. The patient was participating in physical therapy; however, he did not report any improvement. The patient has also been previously treated with massage therapy, electrical stimulation, and a TENS unit. The patient currently reported severe low back pain with numbness and tingling of the lower extremities and right shoulder pain. Physical examination revealed guarding, 145 degrees right shoulder abduction, positive impingement testing, sensory loss in the right hand and distal forearm, and sensory loss over the L5 dermatome on the left foot and leg. Treatment recommendations included a TENS unit and electrodiagnostic testing.

### 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 TENS Page(s): 114-116.

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

**Decision rationale:** California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based TENS trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. There should be documentation of chronic intractable pain and evidence that other appropriate pain modalities have been tried and failed. A one month trial should be documented with evidence of how often the unit was used, as well as outcomes in terms of pain relief and function. As per the clinical notes submitted, the patient has been previously treated with TENS. Although the patient states he received some benefit from the use of the TENS unit, there is no evidence of objective functional improvement. There is no evidence of a treatment plan including specific short-term and long-term goals of treatment with the TENS unit. There is also no evidence of failure to respond to other appropriate pain modalities prior to the request for a TENS unit. Based on the clinical information received and California MTUS Guidelines, the request is non-certified.