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| <b>Case Number:</b>   | CM13-0047522 |                              |            |
| <b>Date Assigned:</b> | 12/27/2013   | <b>Date of Injury:</b>       | 08/15/2009 |
| <b>Decision Date:</b> | 03/11/2014   | <b>UR Denial Date:</b>       | 10/04/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/04/2013 |

### 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 is licensed to practice in California. 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 57-year-old male who reported a work related injury on 08/15/2009, specific mechanism of injury not stated. Subsequently the patient is status post left lateral epicondylectomy and debridement of extensor origin as of 11/13/2010. Most recent clinical note submitted for review is dated 02/28/2013, which reports the patient was seen in a clinic under the care of [REDACTED]. Provider documents the patient reports lumbar spine pain complaints. Provider documented, upon physical exam of the patient, flexion of 60 degrees; 10 degrees of extension were noted to the lumbar spine. Positive straight leg raise bilaterally was evidenced. There was decreased sensation at L4-5 and L5-S1. Provider documented the patient presented with a diagnosis of lumbar radiculitis. Provider recommended the patient undergo lumbar epidural steroid injection and Ultram.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transcutaneous Electrical Joint Stimulation Device System Includes All Accessories:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Stimulation (TENS) Units Page(s): 114-116.

**Decision rationale:** The current request is not supported. The clinical documentation submitted for review fails to evidence the patient has utilized a TENS unit in a trial evidencing duration, and also fails to mention frequency and efficacy of treatment in any of the clinical documents reviewed. California MTUS indicates criteria for the use of TENS includes a 1 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. Given the above, the request for Transcutaneous Electrical Joint Stimulation Device System Includes All Accessories is not medically necessary.