

<b>Case Number:</b>	CM13-0061857		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	02/16/2011
<b>Decision Date:</b>	07/31/2014	<b>UR Denial Date:</b>	11/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2013

### 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. The expert 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 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/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 injured worker is a 43-year-old female who reported an injury on 02/16/2011. Within the documentation submitted for review, the mechanism of injury was noted that the injured worker fell down the stairs, landing on her back and left side of her body. Documented on the clinical note dated 02/01/2013, the injured worker complained of ongoing low back and left knee pain. The documentation noted that the physical examination of the lumbar spine revealed spasm and tenderness to the paralumbar musculature. Sciatic stretch and straight leg raise maneuver were negative. There was query muscle spasm noted with restricted range of motion. Examination of the left knee revealed full range of motion. The injured worker's diagnoses included left shoulder impingement syndrome, L4-5 disc herniation with left sided radiculopathy, left knee tendinitis, and morbid obesity. Previous treatments included aquatic therapy and home exercise program. Medications were not noted within the documentation submitted for review. The provider request was for DME Pro-Stim 5.0 unit. The request for authorization form and rationale were not noted within the documentation submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME-PRO-STIM 5.0 UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN Page(s): 117.

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

**Decision rationale:** The injured worker has a history of low back and left knee pain. The California MTUS states transcutaneous electrical nerve stimulation (TENS unit) is not recommended as a primary treatment modality for chronic pain but a 1 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. The documentation provided noted that the injured worker participated in aquatic therapy, which has been beneficial; however, there is a lack of documentation to indicate the number of sessions attended or remaining. There is also a lack of documentation to indicate any current functional deficits improved upon with therapy. As with the guideline recommendations that a TENS unit may be considered if used as an adjunct to a functional restoration program, there is a lack of documentation to indicate that the requested unit would be used in the recommended manner. Based on the above noted, the request for DME-PRO-STIM 5.0 UNIT is not medically necessary and appropriate.