

<b>Case Number:</b>	CM14-0002050		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	07/13/2008
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	12/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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 & Rehabilitation and is licensed to practice in 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 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 60 year old male who reported an injury on 07/13/2008. The mechanism of injury was not provided in the clinical documentation submitted. Within the clinical note dated 11/03/2009, the injured worker complained of severe low back pain which radiated to the lower left extremity with numbness and tingling which was constant, moderate pain. Upon the physical examination the provider noted obstructed flow of QI, poor circulation, visible decreased range of motion, 2+ tenderness, and moderate spasms of the right lumbar paravertebral musculature with increased range of motion, increased strength, increased endurance, increased ability to perform ADLs, reduced pain behaviors since the last evaluation. The injured worker had the diagnosis of lumbar myalgia. The provider recommended acupuncture and/or electroacupuncture with myofascial release and infrared head therapy for 12 visits. The provider requested retro dual stimulator unit with supplies; however, the rationale was not provided for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **RETROSPECTIVE DUAL STIMULATOR UNIT WITH SUPPLIES FOR DOS**

**11/01/2009 - 02/01/2011:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, CHRONIC PAIN.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114, 116.

**Decision rationale:** The MTUS Chronic Pain Guidelines do not recommend a TENS unit as a primary treatment modality. 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. There was a lack of documentation indicating significant deficits upon the physical exam. There was a lack of documentation indicating the injured worker's previous course of conservative care. There was a lack of documentation indicating how the dual stimulator in the form of a TENS unit would provide the injured worker with functional restoration. There was a lack of documentation indicating if the injured worker had undergone an adequate trial of the TENS unit. Therefore, the request is not medically necessary and appropriate.