

<b>Case Number:</b>	CM14-0011078		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	08/17/2013
<b>Decision Date:</b>	08/06/2014	<b>UR Denial Date:</b>	01/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2014

### 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 Preventive Medicine and is licensed to practice in Indiana. 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 employee is a 32 year old male who sustained a work-related injury one year ago. As a result of that injury, he has been diagnosed with lumbar strain and lumbar radiculopathy. Radiology reports reveal no collapsed disc space and no fracture. As recently as November 2013, the employee noted burning and radicular low back pain radiating to the left leg. He rates the pain as 5-8/10. He is currently taking Deprizine, Dicopanol, Fanatrex, Synaprn, Tabradol, and Cyclophene. He had had several physical therapy visits as well.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION UNIT: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-115.

**Decision rationale:** The above cited guidelines state that transcutaneous electrical nerve stimulation (TENS) is not recommended as a primary treatment modality, but a one-month home-based TEN trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described

below. The medical documentation provided did not demonstrate a one month trial or provide a treatment plan with specific short and long term goals with the TENS unit. Therefore, one (1) Transcutaneous Electrical Nerve Stimulation Unit (TENS) is not medically necessary.