

<b>Case Number:</b>	CM14-0017542		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	05/16/2013
<b>Decision Date:</b>	06/03/2014	<b>UR Denial Date:</b>	01/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2014

### 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 Family Medicine 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 patient is a 55 year old woman who was injured while at work on 5/16/2013. The mechanism of the injury is not stated; however, she presented with complaints of pain involving the neck, shoulders, low back, both wrists and both ankles. She is requesting a review of denial of "complete functional improvement measurements" every 30 days and a Transcutaneous Electrical Nerve Stimulation (TENS) Unit with supplies for 2 months. Her medical records include a comprehensive assessment from her primary treating physician. These records indicate that she has chronic pain in all of the areas described above. Physical examination was done and was notable for tenderness to palpation in all of the areas described above. Diagnoses include the following: Cervical Disc Displacement HNP, Cervical Spine Radiculopathy, Bilateral Shoulder Impingement Syndrome, Bilateral Shoulder Tenosynovitis, Bilateral Wrist Tenosynovitis, Lumbar Disc Displacement HNP, Lumbar Spine Radiculopathy, and Bilateral Ankle Sprain/Strain. She was treated with a number of proprietary medications that included opioids, antiepileptic agents, muscle relaxants and topical NSAIDs. There was an additional request for a TENS Unit, physical therapy, and a Functional Capacity Evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### COMPLETE FUNCTIONAL IMPROVEMENT MEASUREMENTS EVERY 30 DAYS:

Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 33.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines includes a discussion of the goals of Functional Improvement Measures. These criteria state that "functional improvement measures are recommended." These measures can be used repeatedly over the course of treatment to demonstrate improvement in function, or maintenance of function that would otherwise deteriorate. When performed it should include the following categories: Work Functions and/or Activities of Daily Living, Self Report of Disability, Physical Impairments and an Approach to Self-Care and Education. It is expected that these functional improvement measures are documented by the treating provider in the course and scope of the patient's follow-up visits. The request appears to be intended for an outside provider to perform these assessments. An outside assessment for functional improvement measures is not necessary. In summary, the ongoing Functional Improvement Measures are within the course and scope of the treating providers assessment of this patient at the time of the follow-up visits. It is not medically necessary to have these measures assessed by an outside provider.

**TENS UNIT WITH SUPPLIES FOR 2 MONTHS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS UNIT Page(s): 116.

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines provide the criteria for the use of a Transcutaneous Electrical Nerve Stimulation (TENS) Unit. The criteria are as follows: Documentation of pain of at least 3 months duration. There needs to be evidence that other appropriate pain modalities have been tried including medication and have failed. A one-month trial period of a TENS unit should be documented with evidence of how often the unit is used as well as the outcomes in terms of pain relief and function. Based on review of the available records, there is insufficient evidence that other appropriate pain modalities have been tried and have failed. Further, the criteria state that a one-month trial period be used and that there is documentation of its impact on pain relief and function. In summary, there is insufficient evidence that the patient meets the criteria for the use of a TENS Unit and as such it is not considered medically necessary.