

<b>Case Number:</b>	CM14-0018238		
<b>Date Assigned:</b>	04/21/2014	<b>Date of Injury:</b>	06/14/2000
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	01/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 Occupational 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 has submitted a claim for left knee recurrent internal derangement, lumbar discogenic disease with radiculitis, and chronic cervical spine strain/sprain associated with an industrial injury date of 06/14/2000. Treatment to date has included left knee surgery on unspecified date, and medications such as LKG/caps creams, Norco, Anaprox, Flexeril, and Prilosec. Medical records from 2013 to 2014 were reviewed and showed that patient complained of pain at low back, neck, right wrist, and left knee. Physical examination showed spasm at the cervical spine and lumbar spine. There was facet tenderness at the cervical spine, and joint line of left knee. Range of motion of cervical spine and lumbar spine was decreased with presence of pain. There was motor weakness bilaterally graded 4/5. Radiculopathy was noted at C5-C7 and S1 bilaterally. Lasegue test was positive bilaterally. Phalen's and Durkin compression tests were positive at the right wrist. Utilization review from 01/17/2014 denied the request for Prime Dual Electrical Stimulator TENS unit because the medical records did not contain recent clinical assessment that addressed the proposed durable medical equipment (DME). Likewise, there was no summary of diagnostics and treatment rendered to date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRIME DUAL ELECTRICAL STIMULATOR TENS UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS UNIT.

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

**Decision rationale:** As stated on page 114 of CA MTUS Chronic Pain Medical Treatment Guidelines, TENS units are not recommended as a primary treatment modality, but a one-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. In this case, progress reports from December 2013 to February 2014 cited that TENS unit had helped relieve patient's symptoms. Medical records submitted and reviewed do not provide evidence that patient has home exercise program which is a requisite adjunct for TENS. Moreover, as stated in page 116, a treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. There was no documentation submitted regarding specific goals that should be achieved with the use of TENS. In addition, the request is not specific whether the TENS unit is for rental or purchase. Therefore, the request for Prime Dual Electrical Stimulator TENS unit is not medically necessary.