

<b>Case Number:</b>	CM14-0135436		
<b>Date Assigned:</b>	08/27/2014	<b>Date of Injury:</b>	10/24/2011
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	07/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/19/2014

### 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 and 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 medical records submitted reflect that the claimant is a 49 year old male who sustained a work injury on 10-24-11 as a result of repetitive motion. The office visit on 4-16-14 notes the claimant continues with neck pain, upper back pain, low back pain and bilateral shoulder pain, bilateral elbow, wrist hip knee and ankle/foot pain. The claimant ambulates with a cane. Sensation is intact. Office visit on 7-17-14 notes the claimant complains of pain to the neck, low back, both shoulder, both lower extremity pain. On exam, this claimant has decreased range of motion, negative Tinel's, absent DTR, profound weakness bilateral lower extremities. SLR positive bilaterally. The claimant was provided with medications, request for cervical epidural steroid injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Localized Intense Neurostimulation Therapy (LINT):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Lumbar & Thoracic Chapter Localized high-intensity neurostimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrical nerve stimulation Page(s): 114-115.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines notes that transcutaneous electrical nerve stimulation is 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. There is an absence in documentation noting that this claimant has had a trial with daily pain diaries noting functional and documented improvement. Additionally, duration of request is not documented. Therefore, the medical necessity of this request is not established. Therefore, the request is not medically necessary.