

<b>Case Number:</b>	CM14-0022757		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	12/24/2008
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	02/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2014

### 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 and New York. 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 54 year old male who reported an injury on 12/24/2008. The injured worker complained of sternal pain, constant back pain and residual neck left shoulder and hip and groin pain. On physical exam dated on 12/13/2013 there was slight forward head posture. Cervical flexion is at 30 degrees, extension is at 30 degrees, bilateral rotation is at 45 degrees with pain and there is paraspinal spasm. The medications included Metformin and Glyburide. The injured worker diagnoses were not included with documentation. The injured workers treatments/diagnostics MRI dated 11/12/2013 revealed, lumbar vertebral bodies are normal, but demonstrate some narrowing, L3-L4 mild facet hypertrophy, L5-S1 2mm annular disc foraminal protrusion. The authorization form was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS UNIT PURCHASE WITH SUPPLIES:** Upheld

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

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

**Decision rationale:** The request for the TENS unit purchase with supplies is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) chronic pain guidelines states, not recommended as a primary treatment, but a one month home base TENS trial should be documented. Documentation should include how often the machine is being used, as well as the outcome in terms of pain relief and function before purchase can be requested. There should be a documented treatment plan including the specific short-and long term goals of the treatment with the TENS unit as well as documentation of pain of at least three months should be submitted as well. The request is not a medical necessity, in addition has not been supported by documentation, as such the request for TENS purchase with supplies is not medically necessary.