

<b>Case Number:</b>	CM14-0188426		
<b>Date Assigned:</b>	11/19/2014	<b>Date of Injury:</b>	03/24/2014
<b>Decision Date:</b>	01/08/2015	<b>UR Denial Date:</b>	10/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2014

### 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 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:

This is a 36-year-old female with a 3/24/14 date of injury. According to a progress report dated 9/8/14, the patient complained of intermittent dull, achy, and sharp upper/mid back and low back pain. She also complained of bilateral wrist pain with tingling and weakness, with relief from physical therapy. Objective findings: ranges of motion of thoracic spine decreased and painful, tenderness to palpation of lumbar and thoracic paravertebral muscles, muscle spasm of lumbar and thoracic paravertebral muscles, decreased ranges of motion of right and left wrist with pain. Diagnostic impression: thoracic/lumbar sprain/strain and myospasm, lumbar radiculopathy, right and left carpal tunnel syndrome, right and left wrist sprain/strain. Treatment to date: medication management, activity modification. A UR decision dated 10/16/14 denied the request for home TENS unit. A specific rationale was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of home TENS (transcutaneous electrical nerve stimulation) unit for bilateral wrist and hand:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 120-123.

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

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines state that 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. Criteria for the use of TENS unit include Chronic intractable pain - pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, and a treatment plan including the specific short- and long-term goals of treatment with the TENS unit. The patient is noted to have previously used a TENS unit with benefit. However, in the present case, there is no documentation in the reports reviewed addressing any failure of conservative therapy, such as medications. In addition, there is no information as to how the TENS unit is to be used, for which location, over what period of time daily and who will be monitoring the progress. Furthermore, there is no documentation that the TENS unit requested would be used as an adjunct to a program of evidence-based functional restoration. Therefore, the request for Purchase of home TENS (transcutaneous electrical nerve stimulation) unit for bilateral wrist and hand was not medically necessary.