

<b>Case Number:</b>	CM14-0191691		
<b>Date Assigned:</b>	11/25/2014	<b>Date of Injury:</b>	04/01/2008
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	10/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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, has a subspecialty in Pain 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 patient with a date of injury of 4/1/08. A utilization review determination dated 10/31/14 recommends non-certification of FRP evaluation and TENS unit repair/replacement. 10/17/14 medical report identifies pain in the low back, left shoulder, and abdomen due to inguinal hernia. Pain is alleviated with use of medications. He uses Lodine, OTC Tylenol, and Prozac for depressions. He uses TENS twice a day but feels that it has not been functioning. On exam, there is slightly antalgic gait, patient uses cane, there is tenderness and painful ROM. Patient does not want any invasive procedures. Recommendations include FRP evaluation and TENS unit replacement, as it is said to be broken and it helps to improve pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 FUNCTIONAL RESTORATION PROGRAM EVALUATION: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 30-34 and 49.

**Decision rationale:** Regarding the request for a functional restoration program evaluation, California MTUS supports chronic pain programs/functional restoration programs when:

Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; The patient has a significant loss of ability to function independently resulting from the chronic pain; The patient is not a candidate where surgery or other treatments would clearly be warranted; The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & Negative predictors of success [(1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pre-treatment levels of pain] have been addressed. Within the medical information available for review, it is noted that the patient is not interested in invasive procedures, but there is no indication of an absence of other options likely to result in significant clinical improvement. Furthermore, there is no indication of motivation to change and that negative predictors of success described above have been addressed. In the absence of clarity regarding the above issues, the currently requested functional restoration program is not medically necessary.

**1 TENS UNIT REPAIR/REPLACEMENT: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 114-117.

**Decision rationale:** Regarding the request for TENS unit repair/replacement, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) 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. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach, with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Within the documentation available for review, the patient is noted to have a TENS in need of replacement. TENS is said to provide pain relief, but this relief is not quantified and there is no identification of specific functional improvement, decreased usage of pain medication, etc., with TENS use. In the absence of clarity regarding those issues, the currently requested TENS unit repair/replacement is not medically necessary.