

<b>Case Number:</b>	CM14-0203149		
<b>Date Assigned:</b>	12/15/2014	<b>Date of Injury:</b>	02/13/2006
<b>Decision Date:</b>	01/31/2015	<b>UR Denial Date:</b>	11/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/04/2014

### 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 Emergency 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:

Patient with reported date of injury on 2/13/2006. No mechanism of injury was documented. Diagnosis provided are lumbosacral retrolisthesis, lumbosacral anterolisthesis, discopathy, radiculopathy and post foot bunion. Medical reports reviewed. Last report available until 10/30/14. Progress notes are very brief and provide minimal information. Low back pain, severe and radiation was checked off in document. Objective exam only notes lumbar spine tenderness, spasms, decreased range of motion. Kemp's, Straight leg raise positive. Authorization form is dated 11/10/14 with no noted rationale for request. Progress note only list "Continue to request home TENS unit for flare ups of lumbar spine". MRI of lumbar spine(11/7/14) revealed mild scoliosis, mild to moderate bilateral facet changes, grade 1 anterolisthesis L4-5, 2-3mm posterior disc bulge and mild bilateral recess narrowing at L4-5. Independent Medical Review is for TENS unit(purchase), electrodes(4pairs), lead wires, battery(2unit) and installation. Prior Utilization Review on 11/25/14 recommended non-certification.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit (purchase), electrodes x 4 pairs, leadwires, battery x 2 and installation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Transcutaneous electrotherapy Page(s): 114-117.

**Decision rationale:** As per MTUS Chronic pain guidelines, TENS(Transcutaneous Electrical Nerve Stimulation) may be recommended only if it meets criteria. Evidence for its efficacy is poor. Pt does not meet criteria to recommend TENS. TENS is only recommended for neuropathic or Complex Regional Pain Syndrome(CRPS) pain. Patient has a diagnosis of radicular pain. There is no documentation of failures of multiple conservative treatment modalities. Guidelines recommend use only with Functional Restoration program which is not documented. There is no documentation of short or long term goal of TENS unit. There is no documentation of an appropriate 1month trial of TENS. MTUS also recommends rental over purchase, there is no documentation as to why a TENS unit needed to be purchased instead of rented. Patient fails multiple criteria for TENS purchase. TENS is not medically necessary.