

<b>Case Number:</b>	CM15-0004002		
<b>Date Assigned:</b>	01/14/2015	<b>Date of Injury:</b>	02/11/2013
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	01/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New Jersey, New York  
 Certification(s)/Specialty: Family Practice

### 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 34 year old female, who sustained an industrial injury on February 11, 2013. She has reported lower back pain and left leg pain. The diagnoses have included lumbago and lumbar radiculopathy. Treatment to date has included non-steroidal anti-inflammatory drugs, exercise, physical therapy, acupuncture, chiropractic, swimming, transcutaneous electrical nerve stimulation unit, lumbar facet injection, and epidural steroid injection. Currently, the injured worker complains of continued lower back pain with radiation to the left leg. The treating physician is requesting approval for the purchase of a transcutaneous electrical nerve stimulation unit for ongoing pain relief. On January 6, 2015 Utilization Review non-certified the request for the transcutaneous electrical nerve stimulation unit noting the lack of documentation to support the medical necessity of the service. The MTUS Chronic Pain Treatment Guidelines and ODG were cited in the decision.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of TENS Unit for Ongoing Pain Relief, Qty: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

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

**Decision rationale:** The request is not medically necessary. A trial of TENS unit is reasonable as an adjunct to a functional restoration program when other conservative appropriate pain modalities have failed. The patient has already had a trial of a TENS unit with improvement in pain. However, there was no documentation of objective improvement in pain and functional capacity. There was no evidence of reduction in pain medication. Due to lack of sufficient documentation, the request is considered not medically necessary.