

<b>Case Number:</b>	CM15-0007314		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	06/12/2013
<b>Decision Date:</b>	03/16/2015	<b>UR Denial Date:</b>	01/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 29 year old male, who sustained an industrial injury on June 12, 2013. He has reported lower back pain radiating to the upper back and both legs. The diagnoses have included lumbago and lumbar discopathy/radiculopathy and weakness. Treatment to date has included physical therapy, medications, facet blocks, radio frequency rhizotomy, injections, back surgery, and imaging studies. Currently, the injured worker complains of increasing lower back pain without radiation. The treating physician is requesting a transcutaneous electrical nerve stimulation unit. On January 3, 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 treatment. The MTUS chronic pain medical treatment guidelines 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:

**1 TENS Unit (Cypress Care between 12/4/2014 and 4/2/2015): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the Use of TENS , and TENS Post-operative.

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

**Decision rationale:** According to the 12/04/2014 report, this patient continues to experience severe mechanical low back pain which has not responded to the most recent attempts at pain management to include rhizotomy and has no radiation of pain into the lower extremities. The current request is for TENS unit (Cypress Care) between 12/04/014 and 04/02/2015. The request for authorization is on 01/03/2015. The patient's work status is work modified duties. Regarding TENS units, the MTUS guidelines state not recommended as a primary treatment modality, but a one-month home-based unit trial may be considered as a noninvasive conservative option- and may be appropriate for neuropathic pain. The guidelines further state a rental would be preferred over purchase during this trial. In reviewing the provided reports, the Utilization Review denial letter states while the patient is being considered for a lumbar fusion, TENS has not been shown to be sufficiently effective for postoperative pain control in such cases, so the postoperative use of such a unit cannot be supported in this case. In this case, the provided medical records show that the patient does not have neuropathic pain. Furthermore, the request is for four month use of the TENS unit. The MTUS supported a one-month home-based unit trial for neuropathic pain for which this patient does not have. Therefore, the request IS NOT medically necessary.