MAXIMUS Federal Services

| Case Number: | CM15-0008937 | | |
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| Date Assigned: | 01/26/2015 | Date of Injury: | 06/06/2012 |
| Decision Date: | 03/27/2015 | UR Denial Date: | 12/15/2014 |
| Priority: | Standard | Application Received: | 01/14/2015 |

## 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 60-year-old female who reported an injury on 06/06/2012. The mechanism of injury was due to pushing a client in a wheelchair, and tried to hold the client in the chair to prevent a fall due to a violent seizure. Her diagnoses included intervertebral disc disorder; other back symptoms, cervical disc degeneration; lumbosacral neuritis; lumbago; disorder of the coccyx; enthesopathy of the hip; cervical disc displacement; myalgia and myositis; cervicalgia; brachial neuritis; sprain of the neck; sprain of the back; and joint pain in the shoulder. Past treatments include a surgery, TENS unit, selective nerve root block, medications, physical therapy, and a home exercise program. On 06/06/2013, the injured worker complained of low back pain with left leg radiculitis symptoms rated 5/10 with medications and 8/10 without medications. The injured worker also complained of pain radiating to the left hip and complaints of weakness in the upper extremities with overhead reaching and reported grinding in the neck with movements. The physical examination revealed tenderness to palpation over the paraspinous muscles, and positive spasms. An EMG report indicated mild to moderate L5 nerve root abnormality. The exam dated 07/22/2014 revealed the injured worker complained of constant upper and low back pain, with varied pain scales of 6/10 and 1/10 without medications. The injured worker also indicated intermittent pain and numbness in the bilateral lower extremities. Physical examination revealed the cervical range of motion was slightly restricted to all planes; thoracic and lumbar range of motion were moderately restricted to all planes. There were also multiple myofascial trigger points and taut bands noted throughout the cervical paraspinal, trapezius, levator scapulae, scalene, infraspinatus, thoracic or lumbar

paraspinal muscles, as well as in the gluteal muscles. The injured worker also had a positive neck compression test, positive Patrick Fabere's test, with decreased sensation and decreased dorsiflexion. The physical examination dated 09/02/2014 revealed the injured worker complained of constant upper and lower back pain rated 7/10 with medications and 1/10 without medications, with associated symptoms of pain and numbness in the bilateral lower extremities. The physical examination revealed moderately restricted range of motion in the thoracic or lumbar spine, with multiple myofascial trigger points throughout. Her relevant medications included Percocet 10/325 mg. The treatment plan included purchase of supplies for a TENS unit for 03/01/2013, 03/03/2014, 05/01/2014, 07/01/2014 and 09/02/2014. A rationale was not provided. The Request for Authorization form was not submitted for review. This 54-year-old female was injured 6/6/12 in an industrial accident involving her neck, back and shoulders with continuous trauma to the neck, back, wrist, hip, and shoulders. She is currently experiencing constant upper and lower back pain as well as pain and numbness in her bilateral lower extremities. She indicates greater than 60-80% pain relief and improvement in functioning with her current medications. Without her medications, she experiences sleep difficulty. Her pain intensity has decreased from 6-8/10 to 3-4/10. She is better able to perform activities of daily living. She is status post left carpal tunnel release and ulnar nerve anterior transposition, left elbow and is also experiencing aches and pains over the left hand and elbow. She has had a prior work-related injury in 2000 involving her low back and bilateral shoulders. She had back surgery in 2005 which alleviated her pain. Current medications include Tramadol and naproxen. She was treated by pain management, had biofeedback sessions, and had chiropractic sessions. Diagnoses include chronic myofascial pain syndrome, cervical and thoracolumbar, moderate to severe; left L5 radiculopathy; status post-surgery to the lumbar spine (2005); status post-surgery to the right ulnar nerve (11/4/14); status post excision lipoma from the wrist; ulnar nerve anterior transposition , left elbow (11/25/14). Diagnostic studies noted were MRI of the lumbar spine (4/9/14); MRI of the cervical spine; MRI of the left wrist electromyography/ nerve conduction study of the lower extremities; cervical radiographs; radiographs of bilateral knees and lumbar spine. The treating physician ordered a transcutaneous electrical nerve stimulator but specific documentation regarding rationale could not be found. On 12/15/14 Utilization Review non-certified the retrospective request for transcutaneous electrical nerve stimulator unit with service dates of 3/1/13; 3/3/14; 5/1/14; 9/2/14 citing MTUS Guidelines. There was no indication of the effectiveness or amount of usage for the transcutaneous electrical nerve stimulator unit.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective review for dates of service 3/01/2013, 03/03/2014, 05/01/2014, 07/01/2014 and 09/02/2014 for purchase of supplies for transcutaneous electrical nerve stimulator (TENS) unit:** Upheld

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

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

**Decision rationale:** The request for retrospective review for dates of service 03/01/2013, 03/03/2014, 05/01/2014, 07/01/2014 and 09/02/2014 for purchase of supplies for transcutaneous electrical nerve stimulator (TENS) unit is not medically necessary. According to the California MTUS Guidelines, TENS units are not recommended as a primary treatment modality; however, a 1 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. Furthermore, the guidelines indicate that criteria for use of a TENS include: documentation of pain of at least 3 months in duration; evidence that other appropriate pain modalities have been tried and have failed; ongoing pain treatment should be documented during the trial period, including medication usage; undergoing a treatment plan including the specific short and long term goals of treatment should be submitted; documentation that the unit will be used as an adjunct to ongoing treatment modalities with a functional restoration approach. The injured worker was indicated to have put in a request for purchase of TENS unit supply. However, there is a lack of documentation in regard to a physical exam prior to 03/01/2013. Furthermore, there was a lack of documentation to indicate the injured worker had tried other pain modalities that had failed, including medication; had ongoing pain treatment documented during the trial period, including medication usage; that a treatment plan, including the specific short and long term goals with treatment; and lack of documentation the unit was being use as an adjunct ongoing treatment modalities with a functional restoration approach. Given the absence of the above, the request is not supported by the evidence based guidelines. As such, the retrospective request for dates of service 03/01/2013, 03/03/2014, 05/01/2014, 07/01/2014 and 09/02/2014 is not medically necessary. A preauthorization should have been obtained prior to prescribing the service.