

<b>Case Number:</b>	CM15-0166304		
<b>Date Assigned:</b>	09/04/2015	<b>Date of Injury:</b>	04/23/2015
<b>Decision Date:</b>	10/07/2015	<b>UR Denial Date:</b>	07/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/24/2015

### 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: Texas, California  
 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:

This is a 46 year old male patient, who sustained an industrial injury on 4-23-2015. Diagnoses have included lumbar musculoligamentous injury, lumbar myospasm, lumbar radiculopathy and rule out lumbar disc protrusion. According to the progress report dated 6-26-2015, he had complaints of constant, moderate to sharp, stabbing low back pain at 7/10 and stiffness with radiation to both legs. The physical examination revealed a slow and guarded gait, favoring the left lower extremity, tenderness to palpation and spasm of the lumbar paravertebral muscles, pain with Kemp's test bilaterally, pain with Straight leg raise on the right. The current medications list is not specified in the records provided. Treatment to date has included physical therapy. Authorization was requested for a transcutaneous electrical nerve stimulation (TENS) unit and acupuncture for the low back.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit (Indefinite Use), QTY: 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Pain (updated 09/08/15) TENS, chronic pain (transcutaneous electrical nerve stimulation).

**Decision rationale:** According the cited guidelines, 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, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness". Recommendations by types of pain: "A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use)." Per the cited guidelines, there is no high-grade scientific evidence to support the use or effectiveness of electrical stimulation for chronic pain. The patient does not have any objective evidence of CRPS I and CRPS II that is specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications is not specified in the records provided. The medical necessity of TENS unit (Indefinite Use), QTY: 1 is not established for this patient.

**Acupuncture for the low back, QTY: 8:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**Decision rationale:** MTUS guidelines: Acupuncture Medical Treatment Guidelines 9792.24.1. Acupuncture Medical Treatment Guidelines. CA MTUS Acupuncture medical treatment guidelines cited below state that "Acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery." CA MTUS Acupuncture guidelines recommend up to 3 to 6 treatments over 1 to 2 months for chronic pain. Per the cited guidelines "Acupuncture treatments may be extended if functional improvement is documented." The requested visits are more than recommended by the cited criteria. The medical records provided do not specify any intolerance to pain medications. Response to previous conservative therapy including physical therapy and pharmacotherapy is not specified in the records provided. The medical necessity of Acupuncture for the low back, QTY: 8 is not fully established in this patient at this time.