

<b>Case Number:</b>	CM15-0196488		
<b>Date Assigned:</b>	10/12/2015	<b>Date of Injury:</b>	08/21/2012
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	09/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2015

### 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, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 45 year old male, who sustained an industrial injury on 8-21-12. Medical records indicate that the injured worker is undergoing treatment for a cervical strain, post-traumatic headaches and post-concussion syndrome. The injured worker was noted to be temporarily totally disabled. On (8-22-15) the injured worker complained of migraine headaches, intermittent sharp pain, and a tingling sensation in the neck. The pain was rated on average 4 out of 10 on the visual analogue scale. Examination of the cervical spine revealed tenderness to palpation over the parafacet region, cervical three through cervical six vertebrae. Range of motion was mildly decreased during lateral flexion, extension and left side rotation. The rest of the range of motion was within normal limits. Treatment and evaluation to date has included medications, CT scan, physical therapy and chiropractic treatments. A current medication list was not provided in the medical records. The current treatment request is for a transcutaneous electrical nerve stimulation unit. The Utilization Review documentation dated 9-10-15 modified the request for a transcutaneous electrical nerve stimulation unit to a one-month trial (original request transcutaneous electrical nerve stimulation unit).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS (transcutaneous electrical nerve stimulation) unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines do not recommend TENS as a primary treatment modality, but support consideration of a one-month home-based TENS trial used as an adjunct to a program of evidence-based functional restoration. Furthermore, criteria for the use of TENS includes pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, and a documented one-month trial period stating how often the unit was used, as well as outcomes in terms of pain relief and function. The documentation submitted for review does not indicate that the injured worker has successfully undergone TENS unit trial. As such, the request is not medically necessary.