

<b>Case Number:</b>	CM15-0023173		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	05/21/2014
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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: Hawaii, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 40 year old female who sustained an industrial related injury on 5/21/14. The injured worker had complaints of left hand, left wrist, and left elbow pain with numbness and tingling. Diagnoses included left wrist pain, left hand pain, left elbow pain, left carpal tunnel syndrome, left cubital tunnel syndrome, and left upper extremity overuse syndrome. Carpal tunnel and cubital tunnel syndromes were both confirmed by an electromyography study. Treatment included a volar wrist splint, Smart Glove, a Pil-O splint, acupuncture, and physical therapy. The treating physician requested authorization for a 5 month rental for a multi-stimulation unit plus supplies. On 1/16/15 the request was non-certified. The utilization review physician cited the Medical Treatment Utilization Schedule guidelines and noted the request did not specify which functions were to be used with the multi-stimulation unit. There was also no documentation of a successful one month trial with a multi-stimulation unit. Therefore the request was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Durable Medical Equipment- Multi Stim Unit Plus Supplies for a 5 month rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
TENS Page(s): (s) 114-115.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120. Decision based on Non-MTUS Citation Pain, TENS chronic pain (transcutaneous electrical nerve stimulation)

**Decision rationale:** MTUS states regarding TENS unit, “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.” For pain, MTUS and ODG recommend TENS (with caveats) for neuropathic pain, phantom limb pain and CRPSII, spasticity, and multiple sclerosis. The medical records do not indicate any of the previous conditions. ODG further outlines recommendations for specific body parts: Low back: Not recommended as an isolated intervention Knee: Recommended as an option for osteoarthritis as adjunct treatment to a therapeutic exercise program Neck: Not recommended as a primary treatment modality for use in whiplash-associated disorders, acute mechanical neck disease or chronic neck disorders with radicular findings Ankle and foot: Not recommended Elbow: Not recommended Forearm, Wrist and Hand: Not recommended Shoulder: Recommended for post-stroke rehabilitation Medical records do not indicate conditions of the low back, knee, neck, ankle, elbow, or shoulders that meet guidelines. Of note, medical records do not indicate knee osteoarthritis. ODG further details criteria for the use of TENS for Chronic intractable pain (for the conditions noted above): (1) Documentation of pain of at least three months duration. (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed. (3) A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. (4) Other ongoing pain treatment should also be documented during the trial period including medication usage. (5) A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. (6) After a successful 1-month trial, continued TENS treatment may be recommended if the physician documents that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. At this point purchase would be preferred over rental. (7) Use for acute pain (less than three months duration) other than post-operative pain is not recommended. (8) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. The medical records do not satisfy the several criteria for selection specifically, lack of documented 1-month trial, lack of documented short-long term treatment goals with TENS unit, and unit use for acute (less than three months) pain. An initial request for 5 months is in excess of guidelines. As such, the request for Durable Medical Equipment- Multi Stim Unit Plus Supplies for a 5 month rental is not medically necessary as written.