

<b>Case Number:</b>	CM15-0031681		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	11/11/2005
<b>Decision Date:</b>	04/06/2015	<b>UR Denial Date:</b>	02/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2015

### 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, 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 55 year old female, who sustained a work related injury on 11/11/05. The diagnoses have included adhesive capsulitis of shoulder, lumbosacral disc degeneration and chronic fatigue syndrome. Treatments to date have included oral medications, Duragesic patches, MRIs of cervical and lumbar spine and previous TENS unit therapy. In the PR-2 dated 2/5/15, the injured worker complains of chronic cervical and right shoulder pain associated with stiffness and weakness. She complains of worsening low back and coccyx pain and cannot sit in chair for too long. She has lost voluntary bowel function and has to self evacuate. She has trouble with emptying her bladder. She complains of severe shoulder pain. She has severe fatigue. On 2/12/15, Utilization Review non-certified a request for a TENS unit with supplies for rental or purchase. The California MTUS, Chronic Pain Treatment Guidelines, were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit and supplies/electrodes for rent or purchase:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 114-117 of 127.

**Decision rationale:** Regarding the request for TENS, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (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. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial 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. Within the documentation available for review, there is no indication that the patient has undergone a TENS unit trial (and there is no provision to modify the request for a 30-day trial), and no documentation of any specific objective functional deficits which a TENS unit trial would be intended to address. Additionally, it is unclear what other treatment modalities are currently being used within a functional restoration approach. In the absence of clarity regarding those issues, the currently requested TENS unit is not medically necessary.