

<b>Case Number:</b>	CM15-0031720		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	08/05/1992
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	01/29/2015
<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, Arizona

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 53-year-old male who reported an injury on 08/05/1992. The mechanism of injury was unspecified. His diagnoses include lumbar degenerative disc disease, chronic back pain, skin psoriasis, peripheral neuropathy, and cerebral palsy. On 01/21/2015, the injured worker presented for a follow-up, complaining of severely increased pain due to lack of medications, and a worn out TENS unit. The injured worker also indicated that the TENS unit was noted to have helped relieve his pain. The physical examination revealed tenderness and muscle spasms at the paraspinals and trigger points at the bilateral sciatic, iliac crest, and bilateral paraspinals. His range of motion was indicated to be reduced by 50%, with abnormal sensation and deep tendon reflexes. The treatment plan included a TENS unit and medication refill. A rationale is not provided. A Request for Authorization form was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**GSM HD combo purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of TENS.

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

**Decision rationale:** According to the California MTUS Guidelines, transcutaneous electrotherapy 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. The criteria for the use of a TENS unit after the one month trial include: documentation of how often the unit was used, as well as outcomes in terms of pain relief and function and ongoing treatment modalities within a functional restoration approach. Furthermore, the guidelines state other ongoing pain treatment should also be documented during the trial period including medication usage. The injured worker was noted to have used the TENS unit previously, and indicated relief of pain with use. However, there was a lack of documentation in regard to the unit being used in adjunct to a program of evidence based functional restoration. There was also a lack of documentation in regard to how often the unit was used, outcomes in terms of pain relief, function, and ongoing treatment modalities with any functional restoration approach. Furthermore, there was lack of documentation in regard to ongoing pain treatment during the trial period, to include medication usage. Moreover, there was lack of documentation the unit was unrepairable. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

**TENS unit with han programs and supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of TENS.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Electrodes, 8 pairs per month:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of TENS.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Batteries, 6 units per month:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of TENS.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.