

<b>Case Number:</b>	CM15-0045984		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	06/25/2013
<b>Decision Date:</b>	04/17/2015	<b>UR Denial Date:</b>	02/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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: Connecticut, California, Virginia  
 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 49 year old male patient, who sustained an industrial injury on 06/25/2013. A primary treating office visit dated 01/15/2015, reported the patient's pain is stable. He reports the same amount of headaches over the last two weeks. The Trazadone is helping with insomnia. Prior treatment includes: physical therapy, chiropractic therapy and oral medications. The patient has subjective complaint of head, neck, upper back, right shoulder, right arm, right elbow, right wrist and bilateral hand pain. The pain is associated with numbness, tingling and weakness in the hands. The pain is constant in frequency and moderate to severe in intensity. The pain is rated a 7 out of 10 in intensity. The pain is described as sharp with pins and needles sensation and skin sensitivity to light touch. The pain is relieved with rest and medications and sometimes relaxing. Objective findings showed tenderness to palpation over the bilateral cervical paraspinal muscles. There is positive Spurling's maneuver on the right. There is diminished sensation in the right C6 and C7 dermatomes of the upper extremity. The following diagnoses are applied: displacement of cervical intervertebral disc without myelopathy and hypertensive disorder. The following medications are currently prescribed: Ultram 50mg, Anaprox 550mg, and Trazadone 50mg. Utilization Review non-certified a request for retrospective ongoing supplies for existing TENS unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective ongoing supplies for existing TENS unit (DOS: 1/15/15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

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

**Decision rationale:** With respect to chronic pain and according to the MTUS, 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 conditions including: Complex regional pain syndrome, neuropathic pain, phantom limb pain, spasticity, and multiple sclerosis. The MTUS states that although electrotherapeutic modalities are frequently used in the management of chronic low back pain, few studies were found to support their use. Most studies on TENS can be considered of relatively poor methodological quality. MTUS criteria for use include documentation of pain of at least three months duration and evidence of failure of other modalities in treating pain (including medications). In this case the patient has not been diagnosed with a condition where use of TENS has shown proven benefit, and a treatment plan outlining short and long term goals for TENS therapy has not been established per the provided records. This is a retrospective request for equipment but the provided records show no evidence of objective functional improvement with TENS therapy. Therefore at this time and based on the provided records, the request for cannot be considered medically necessary.