

<b>Case Number:</b>	CM15-0046947		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	11/05/1992
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2015

### 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

### 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 60 year old male, who sustained an industrial injury on 11/05/1992. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having lumbar disc herniation, lumbar stenosis, failed laminectomy syndrome, and lumbar disc disease. Treatment to date has included electromyogram with nerve conduction study, laboratory studies, lumbar magnetic resonance imaging, cervical magnetic resonance imaging, thoracic magnetic resonance imaging, medication regimen, status post multiple lumbar surgeries, and status post left shoulder surgery. In a progress note dated 02/10/2015 the treating provider reports complaints of cervical pain, low back pain, and left wrist pain. The treating physician also noted tenderness to palpation to the lumbar spine with spasms, tenderness to the right knee joint, and a decreased sensation to the left posterolateral thigh, calf, and foot. The treating physician requested a transcutaneous electrical nerve stimulation unit for treatment but the documentation did not indicate the specific reason for the request a 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 unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Chronic Pain (transcutaneous electrical nerve stimulation).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-121.

**Decision rationale:** The patient presents on 02/10/15 with unrated cervical pain, lumbar pain, and left wrist pain. The patient's date of injury is 11/05/92. Patient is status post lumbar laminectomy and discectomy at L2-L3 on 06/12/08, status post bilateral L2-L3 laminectomy and partial facetectomy for nerve root decompression with posterolateral transverse process fusion on 03/09/13. Patient also underwent laminectomy and discectomy at unspecified levels in 1994 and 1996 and unspecified left shoulder surgery on 12/09/10. The request is for TENS Unit. The RFA is dated 02/24/15. Physical examination dated 02/10/15 reveals tenderness to palpation of the lumbar spine/paraspinal muscles, positive straight leg raise test on the right, decreased sensation over the left posterolateral thigh, calf, and foot. Tenderness over the right knee joint is also noted. The patient is currently prescribed Percocet. Diagnostic imaging was not included. Patient's current work status was not provided. MTUS Chronic Pain Medical Treatment Guidelines, pg114-121, Criteria for the use of TENS states 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. Guidelines indicate documentation of use of TENS, as an adjunct to other treatment modalities, within a functional restoration approach. In this case, the provider has not indicated how or if the unit worked in the past. The provider does not specify if this is to be a 30 day rental or a purchase, does not provide evidence of a successful 30 day trail performed previously, and has not documented how the TENS is to be used either. Therefore, the request is not medically necessary.