

<b>Case Number:</b>	CM15-0088226		
<b>Date Assigned:</b>	05/12/2015	<b>Date of Injury:</b>	12/07/2005
<b>Decision Date:</b>	06/15/2015	<b>UR Denial Date:</b>	04/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2015

### 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: New York, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency 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 65 year old female, who sustained an industrial injury on 12/07/2005. She reported low back pain which radiated to both lower extremities. The injured worker is currently permanent and stationary. The injured worker is currently diagnosed as having lumbar degenerative disc disease, cervical degenerative disc disease, and multiple joint pain. Treatment and diagnostics to date has included physical therapy, lumbar spine MRI, cervical spine MRI, right shoulder MRI, left shoulder MRI, left knee MRI, right knee MRI, electromyography of the lower extremities, Transcutaneous Electrical Nerve Stimulation Unit, and medications. In a progress note dated 10/24/2014, the injured worker presented with complaints of low back and bilateral lower extremity pain, neck pain, bilateral shoulder pain, bilateral knee pain, an bilateral hand pain. Objective findings include lumbar and cervical spine tenderness. The treating physician reported requesting authorization for Transcutaneous Electrical Nerve Stimulation Unit, stating that her current unit is broken.

### 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.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS  
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**Decision rationale:** Guidelines indicate that TENS is not recommended as a primary treatment modality, but a one month trial may be considered if used as an adjunct to a program of evidence based functional restoration for neuropathic pain. In this case, the medical records do not document neuropathic pain indication for TENS and records are unclear regarding the functional benefit of prior TENS use. The request for TENS unit is not medically appropriate and necessary.