MAXIMUS Federal Services

| Case Number: | CM15-0089905 | | |
|---|---|---|---|
| Date Assigned: | 05/14/2015 | Date of Injury: | 04/26/2011 |
| Decision Date: | 08/24/2015 | UR Denial Date: | 04/30/2015 |
| Priority: | Standard | Application Received: | 05/11/2015 |

## 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: Texas, California
Certification(s)/Specialty: Family Practice

## 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 35 year old male, who sustained an industrial injury on 4/26/11. Initial complaint was of a low back injury. The injured worker was diagnosed as having lumbar strain/sprain; displacement of thoracic or lumbar intervertebral disc without myelopathy. Treatment to date has included medications. Currently, the PR-2 notes dated 4/13/15 are hand written. These notes indicated the injured worker complains of continued pain in the low back with right greater than the left and numbness to the right foot. Pain is described as shooting down the right leg. He has positive lower paraspinal spasms with weakness and decreased range of motion. The patient has had positive SLR, muscle spasm and limited range of motion. He is requesting a MRI of the lumbar spine for evaluate for possible herniated disc, medications and a TENS unit. The provider is requesting authorization of a TENS unit. The medication list include Norco, Soma and Medrol dose pack. Other therapy done for this injury was not specified in the records provided.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Transcutaneous electrical nerve stimulation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114.

**Decision rationale:** Request: Transcutaneous electrical nerve stimulation. According the cited guidelines, electrical 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, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness". Recommendations by types of pain: "A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use)." According the cited guidelines, Criteria for the use of TENS is "There is evidence that other appropriate pain modalities have been tried (including medication) and failed". "A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted". Any evidence of neuropathic pain, CRPS I and CRPS II was not specified in the records provided. Details of PT or other type of therapy done since date of injury was not specified for this injury. Detailed response to previous conservative therapy was not specified in the records provided. In addition a treatment plan including the specific short and long-term goals of treatment with the TENS unit was not specified in the records provided. The records provided did not specify any recent physical therapy with active PT modalities or a plan to use TENS as an adjunct to a program of evidence-based functional restoration. Any evidence of diminished effectiveness of medications or intolerance to medications or history of substance abuse was not specified in the records provided. The medical necessity of the request for Transcutaneous electrical nerve stimulation is not fully established for this patient.