

<b>Case Number:</b>	CM14-0119863		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	12/21/2012
<b>Decision Date:</b>	10/20/2014	<b>UR Denial Date:</b>	06/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 records, presented for review, indicate that this 31-year-old male was reportedly injured on 12/21/2012. The claimant suffered a T12 fracture requiring a T10-L2 posterior instrumentation and fusion in March 2013. The most recent progress notes, dated 5/21/2014 and 7/9/2014, indicate that there were ongoing complaints of low back pain with radiation to the right lower extremity. Physical examination demonstrated 5/5 quadriceps, knee extension, knee flexion, foot dorsiflexion, plantar flexion and EHL motor strength. Incision was completely healed. A lumbar CT, dated 3/6/2014 and lumbar MRI dated 5/19/2014, demonstrated a mild disk bulge at L5-S1 without stenosis, T12 anterior wedge fracture, status post posterior stabilization and instrumentation with pedicle screws at T10, T 11, L1 and L2 without pseudoarthrosis and minimal degenerative disk disease of the lower lumbar spine without significant canal or foraminal narrowing. EMG/NCV study of the lower extremities, dated 3/5/2014, showed evidence of bilateral L4 radiculopathy and cannot exclude chronic bilateral L2-L3 radiculopathy. Previous treatment included spine fusion and physical therapy. A request had been made for TENS unit and supplies E0730, A4556, A4245, A4630 for purchase, which were not certified in the utilization review on 6/30/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit and supplies E0730, A4556, A4245, A4630 for purchase: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114, 116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-114.

**Decision rationale:** MTUS treatment guidelines recommends against using a TENS unit as a primary treatment modality and indicates that a one-month trial must be documented prior to purchase of the unit. Based on the clinical documentation provided, physical therapy and a TENS unit is helping significantly; however, there is no documentation of a full one-month trial. The MTUS requires that an appropriate one-month trial should include documentation of how often the unit was used, the outcomes in terms of pain relief/reduction and improvement in function. Review of the available medical records fails to document a required one-month TENS unit trial. As such, this request is not considered medically necessary.