MAXIMUS Federal Services

| Case Number: | CM14-0137164 | | |
|---|---|---|---|
| Date Assigned: | 09/05/2014 | Date of Injury: | 11/17/2009 |
| Decision Date: | 10/09/2014 | UR Denial Date: | 07/30/2014 |
| Priority: | Standard | Application Received: | 08/25/2014 |

## 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 Orthopedic Surgery, and is licensed to practice in Texas. 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 injured worker is a 58-year-old male who reported an injury on 11/17/2009; the mechanism of injury is not provided. On 07/07/2014, the injured worker presented with neck pain. Upon examination, the cervical range of motion is painful specifically with right rotation and extension. There was normal bilateral upper extremity strength. Diagnoses were multilevel degenerative spondylolisthesis and degenerative disc disease C3 through C7, bilateral C6-7 radicular numbness and tingling, trapezius and interscapular myofascial pain and spasm, C3-4 disc osteophyte complex effacing the right ventral subarachnoid space and contacting and flattening the cord with severe right neural foraminal narrowing and C6-7 central annular fissure on the left 7 mm. Prior therapy included medications, home exercise, and the use of a home TENS unit. The provider recommended a purchase of a TENS unit, the provider's rationale was not provided. The Request for Authorization Form was not included in the medical documents for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase TENS unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Electrotherapy/Transcutaneous Electrical Nerve Stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENs Page(s): 116.

**Decision rationale:** The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A 1 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. The results of studies are inconclusive and the published trials do not provide information on the stimulation parameters that provide optimum pain relief. There is lack of documentation indicating significant deficits upon physical examination. Efficacy of the injured worker's prior course of conservative care were not provided. The length of time the injured worker underwent a home based TENS trial was not provided and the efficacy of the home based TENS trial was not included in the medical documents for review. The provider's request does not indicate a site at which the TENS unit is intended for in the request as submitted. As such, medical necessity has not been established.