

<b>Case Number:</b>	CM14-0181638		
<b>Date Assigned:</b>	11/06/2014	<b>Date of Injury:</b>	07/07/2014
<b>Decision Date:</b>	12/09/2014	<b>UR Denial Date:</b>	10/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2014

### 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 Pain Management and Rehabilitation, 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:

This patient sustained an injury on 7/7/14 while employed by [REDACTED]. Request(s) under consideration include Prime Dual Electrical Stimulator (TENS-EMS) unit and supplies (Rental or Purchase). Diagnoses include lumbar disc displacement without myelopathy. Report of 8/28/14 from the provider noted the patient with continued chronic low back pain symptoms with radiation down hips and legs. Conservative care has included medications, therapy/chiropractic sessions, and modified activities/rest. Exam showed lumbar spine spasm, tenderness to bilateral paraspinal muscles from L1-S1 and multifidus; limited lumbar range with flex/ext/bilateral side bending and rotation 30/10/5/10 degrees with pain; positive bilateral Kemp's, Yeoman's and SLR on the right with decreased right Achilles reflex. The patient remained not working. Treatment included PT, lumbosacral orthosis, FCE, work hardening, psychosocial factors, and IF unit. The patient remained TTD. The request(s) for Prime Dual Electrical Stimulator (TENS-EMS) unit and supplies (Rental or Purchase) was non-certified on 10/2/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prime Dual Electrical Stimulator (TENS-EMS) unit and supplies (Rental or Purchase):**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain Page(s): 114-117.

**Decision rationale:** This patient sustained an injury on 7/7/14 while employed by [REDACTED]. Request(s) under consideration include Prime Dual Electrical Stimulator (TENS-EMS) unit and supplies (Rental or Purchase). Diagnoses include lumbar disc displacement without myelopathy. Report of 8/28/14 from the provider noted the patient with continued chronic low back pain symptoms with radiation down hips and legs. Conservative care has included medications, therapy/chiropractic sessions, and modified activities/rest. Exam showed lumbar spine spasm, tenderness to bilateral paraspinal muscles from L1-S1 and multifidus; limited lumbar range with flex/ext/bilateral side bending and rotation 30/10/5/10 degrees with pain; positive bilateral Kemp's, Yeoman's and SLR on the right with decreased right Achilles reflex. The patient remained not working. Treatment included PT, lumbosacral orthosis, FCE, work hardening, psychosocial factors, and IF unit. The patient remained TTD. The request(s) for Prime Dual Electrical Stimulator (TENS-EMS) unit and supplies (Rental or Purchase) was non-certified on 10/2/14. Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, the patient has received extensive conservative medical treatment to include analgesics and other medication, physical therapy, activity modifications/rest, yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, functional improvement from trial treatment, nor is there any documented short-term or long-term goals of treatment with the TENS unit. There is no evidence for change in work status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from any TENS treatment already rendered. The Prime Dual Electrical Stimulator (TENS-EMS) unit and supplies (Rental or Purchase) is not medically necessary and appropriate.