

<b>Case Number:</b>	CM15-0011797		
<b>Date Assigned:</b>	01/30/2015	<b>Date of Injury:</b>	11/21/2007
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	01/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/20/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 49 year old female who sustained a work related injury on 11/21/07. Diagnoses include recurrent neck pain with cervical radiculopathy, cervicogenic headaches, left occipital neuralgia, right shoulder pain, lumbar sprain/strain, lumbar sprain/strain and disc protrusions, right lower extremity radiculitis symptoms, recurrent deQuervain's, and anxiety and depression due to chronic pain. Past surgical history also included right shoulder arthroscopic surgeries on 7/1/09 and 7/13/11. She underwent deQuervain's release of the right wrist in 2008, and deQuervain's release, neurolysis of the superficial radial nerve, and scar tissue release on 7/1/14. The 7/17/14 orthopedic surgery report cited post-operative evaluation. The injured worker reported right wrist/hand pain and swelling along her right wrist/hand, and inability to move it or use it much. Difficulty was noted with activities of daily living. Physical exam documented intact sutures and no signs of infection. Right wrist range of motion was moderate to markedly limited with grossly 4+/5 right upper extremity strength. She was unable to grip. The treatment plan included start post-op physical therapy for the right wrist/hand and follow-up with primary treating physician. The pain management reports from 6/18/14 through 1/29/15 do not discuss the use of a TENS unit. On 01/05/15 Utilization Review non-certified electrodes and TENS machine purchase, citing MTUS, ACOEM, and ODG guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Electrodes, 18 pairs:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain and Forearm, Wrist & Hand Chapters

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Retro Sterile electrodes, two pairs:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain and Forearm, Wrist & Hand Chapters

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Retro TENS unit for purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain and Forearm, Wrist & Hand Chapters

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** The California MTUS Chronic Pain Guidelines recommend the use of transcutaneous electrotherapy in the treatment of pain when specific indications are met for individual electrotherapy modalities. In general, the guidelines do not recommend the use of any form of electrical stimulation as a primary treatment modality. A one-month trial is supported for TENS units if there is chronic intractable pain of 3 months duration and other appropriate pain modalities (including medication) have been tried and failed. TENS may be used as a treatment option for acute post-operative pain in the first 30 days after surgery. TENS appears to be most effective for mild to moderate thoracotomy pain. It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. Guidelines state that the proposed necessity of the unit should be documented. Guidelines have not been met. Guideline criteria have not been met. Under consideration is a retrospective request for a TENS unit purchase. There is no documented indications for the use of this unit. There is no documentation of a prior TENS unit trial with

reduction in pain and medication use, or improvement in function. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications. Therefore, this request is not medically necessary.