

<b>Case Number:</b>	CM15-0013759		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	11/26/2013
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	01/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/23/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 female, who sustained a work related injury November 26, 2013. While moving boxes she experienced low back pain and right sided leg pain. She was initially treated with ice, medication, back brace, heat pad and six visits of chiropractic treatment. Later she received physical therapy and care with an acupressure therapist which moderately improved her pain. According to a physician's progress report, dated December 23, 2014, the injured worker presented with low back pain intermittent and described as dull and sharp at times, rated 4/10, radiating down the right leg associated with a tingling sensation. She noted sleep disturbance due to pain. Diagnosis is documented as lumbosacral strain. Treatment plan included conservative care with medications as needed and exercise, request for epidural steroid injection consultation, continue physical therapy and a TENS Unit which was dispensed in the clinic and educated to its proper use. Work status is documented as return to work with modification. According to utilization review dated January 9, 2015, the request for (retrospective, DOS 12/24/2014) purchased TENS Unit is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for Purchase of TENS unit (DOS: 12/24/14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous Electrical Nerve Stimulation Page(s): 97.

**Decision rationale:** According to MTUS guidelines, TENS is not recommended as primary treatment modality, but a one month based trial may be considered, if used as an adjunct to a functional restoration program. There is no evidence that a functional restoration program is planned for this patient. Furthermore, there is no clear information about a positive one month trial of TENS. There is no recent documentation of recent flare of her pain. The provider should document how TENS will improve the functional status and the patient's pain condition. Therefore, the prescription of TENS unit (purchase) is not medically necessary.