

<b>Case Number:</b>	CM15-0019526		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	12/18/2008
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	12/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/02/2015

### 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:

A 49 year old female who sustained an industrial injury on 12/18/2008, Current diagnoses include herniated nucleus propulsus lumbar spine, herniated nucleus propulsus cervical spine, complex regional pain syndrome (CRPS) with failed spinal cord stimulator, and right trochanteric bursitis. Previous treatments included medication management, chiropractic therapy, physical therapy, epidural steroid injections, neuro stimulator implant and removal, TENS unit, and cervical fusion on 11/18/2014. Report dated 12/09/2014 noted that the injured worker presented with complaints that included neck, mid back, and low back pain. Physical examination was positive for abnormal findings. Utilization review performed on 12/30/2014 non-certified a prescription for TENS unit supplies, based on the clinical information submitted does not support medical necessity. The reviewer referenced the California MTUS and Official disability Guidelines in making this decision.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS.

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

**Decision rationale:** According to MUTUS guidelines, TENS is not recommended as primary treatment modality for neuropathic pain, but a one month based trial may be considered, if used as an adjunct to a functional restoration program. It could be recommended as an option for acute post operative pain in the first 30 days after surgery. There is no documentation that the patient developed neuropathic pain or that a functional restoration program is planned in parallel with TENS. Therefore, the request of TENS unit supplies is not medically necessary.