

<b>Case Number:</b>	CM15-0113601		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	04/26/2013
<b>Decision Date:</b>	07/20/2015	<b>UR Denial Date:</b>	05/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 sustained an industrial injury on April 26, 2013. He has reported lower back pain and has been diagnosed with lumbosacral musculoligamentous strain/sprain with radiculitis and multiple disc protrusions with intervertebral foraminal/spinal stenosis. Treatment has included medications, a TENS unit, hot and cold unit, modified work duty, and acupuncture. There was tenderness to palpation to the bilateral frontal area. There was lumbar spine tenderness to palpation bilateral paraspinal muscles/sacroiliac joints/sciatic notch/posterior iliac crests/gluteal muscles. There were spasms to the bilateral paraspinal muscles and gluteal muscles with decreased range of motion. There was a positive straight leg raise. The treatment request included a TENS unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS (transcutaneous electrical nerve stimulation): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation). Decision based on Non- MTUS Citation Official Disability Guidelines: Low Back - TENS (transcutaneous electrical nerve stimulation).

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

**Decision rationale:** 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 chronic condition and has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive therapy, activity modifications, yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, whether this is for rental or purchase, nor is there any documented short-term or long-term goals of treatment with the TENS unit. Although the patient has utilized the TENS unit for some time, there is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the TENS treatment already rendered. The TENS (transcutaneous electrical nerve stimulation) is not medically necessary and appropriate.