

<b>Case Number:</b>	CM15-0113829		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	01/09/2010
<b>Decision Date:</b>	07/29/2015	<b>UR Denial Date:</b>	05/08/2015
<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: Texas, California  
 Certification(s)/Specialty: Family Practice

### 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 is a 67 year old male patient, who sustained an industrial injury on 1/9/10. The diagnoses include lumbar degenerative disc disease. He sustained the injury while carrying a blower. Per the doctor's note dated 4/27/2015, he had complaints of low back and right lower extremity pain. He had complains of low back pain and pain in the lateral aspect of the right leg with numbness; right foot drop. The physical examination revealed antalgic gait, tenderness and 4/5 strength in lower extremities, positive straight leg raising test on the right. The medications list includes tramadol and gabapentin. He has had lumbar MRI dated 10/20/2014; EMG/NCS dated 5/23/2014. Treatment to date has included right L4-5 and L5-S1 transforaminal epidural steroid injection, physical therapy and TENS. The treating physician requested authorization for a TENS unit with supplies for home use and a follow-up appointment with [REDACTED].

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit with supplies for home use:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-116.

**Decision rationale:** According the cited guidelines, TENS is "not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters, which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness.

Recommendations by types of pain: A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use)." Per the MTUS chronic pain guidelines, there is no high-grade scientific evidence to support the use or effectiveness of electrical stimulation for chronic pain. Cited guidelines do not recommend TENS for chronic pain. The patient does not have any objective evidence of CRPS I and CRPS II that is specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications is not specified in the records provided. The TENS unit with supplies for home use is not medically necessary for this patient.

**Follow-up appointment:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, Independent Medical Examinations and Consultations, page 127.

**Decision rationale:** Per the cited guidelines, "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." Per the records provided patient had low back pain radiating to the right lower extremity. He had significant objective findings including tenderness, decreased strength, right foot drop and positive straight leg raising on the right. There was objective evidence of conditions that can cause chronic pain with episodic exacerbations. Therefore follow up visits are medically appropriate and necessary. The request for Follow-up appointment is medically necessary for this patient at this juncture.