

<b>Case Number:</b>	CM15-0060531		
<b>Date Assigned:</b>	04/06/2015	<b>Date of Injury:</b>	02/04/2013
<b>Decision Date:</b>	05/07/2015	<b>UR Denial Date:</b>	03/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/30/2015

### 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, New York  
 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:

The injured worker is a 34-year-old female, who sustained an industrial injury on 2/4/13. The injured worker has complaints of neck and upper back pain. The diagnoses have included neck pain; fusion of cervical spine; right shoulder joint pain; history of arthroscopic shoulder surgery; bilateral scapulargia and history of carpal tunnel surgery. Treatment to date has included physical therapy with temporary relief; status post anterior cervical discectomy with cervical fusion C5-6 level on 12/10/13; right shoulder arthroscopy, subacromial decompression and labral debridement on 9/4/14 and transcutaneous electrical nerve stimulation unit. The request was for transcutaneous electrical nerve stimulation unit and supplies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit and supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
 Transcutaneous electrotherapy Page(s): 114-116.

**Decision rationale:** The request is not medically necessary. A TENS unit is reasonable as an adjunct to a functional restoration program when other conservative appropriate pain modalities have failed. The patient has tried multiple treatment modalities and was documented to be non-compliant with home exercises. As per MTUS guidelines, TENS "does not appear to have an impact on perceived disability or long-term pain" and is also used in treatment of neurogenic pain, which the patient was not documented to have. There should also be documentation of long and short-term goals as well as medication usage during the trial. Objective documentation of improvement in pain and function should also be included in the chart. Because of lack of documentation, the request is considered not medically necessary.