

<b>Case Number:</b>	CM15-0093783		
<b>Date Assigned:</b>	05/20/2015	<b>Date of Injury:</b>	06/26/2001
<b>Decision Date:</b>	06/25/2015	<b>UR Denial Date:</b>	05/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2015

### 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, Alabama, 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 46-year-old male who sustained an industrial injury on 6/26/01. The mechanism of injury is unclear. Medications were not indicated. On physical exam, there was tenderness over the thoracic hardware bilaterally. The hardware is palpable. X-rays show stable appearing hardware of loosening or pseudoarthrosis. He had removal of thoracic hardware 2/12/15 because of pain related to the hardware. Diagnoses include displacement of the thoracic intervertebral disc without myelopathy; post-laminectomy syndrome of thoracic region; tear of medial cartilage or meniscus of the knee; supraspinatus tear; knee arthroscopies; anterior cervical discectomy and fusion. Treatments to date were not indicated including a trial of transcutaneous electrical nerve stimulator unit. On 5/11/15, Utilization Review accessed the request for transcutaneous electrical nerve stimulator unit for purchase.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrical nerve stimulator (TENS) Page(s): 116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous Electrical Nerve Stimulation Page(s): 114-116.

**Decision rationale:** According to MUTUS 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.