

<b>Case Number:</b>	CM14-0008444		
<b>Date Assigned:</b>	02/12/2014	<b>Date of Injury:</b>	06/06/2013
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	01/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 49-year-old male who reported an injury on 06/06/2013. The mechanism of injury was the amputation to a third of the right thumb while placing his hand on a machine. Within the clinical note dated 11/18/2013, the injured worker complained of residual pain in the right thumb. He also complained of right wrist pain which the injured worker described as constant, mild to moderate. He rated the pain 4/10 in severity. The injured worker reported pain was aggravated by gripping, grasping, reaching, pulling, and lifting. Upon the physical examination, the provider noted tenderness to palpation on the distal phalanx. The provider also noted bilateral neuromas of the ulnar and radial digital nerves are tenderness to palpation. The physician indicated diminished sensation to pinprick and light touch along the distribution of the ulnar and radial nerve. The diagnoses included right wrist pain, status post right thumb distal phalanx amputation. The injured worker underwent a right thumb surgery on 06/06/2013. The provider requested a TENS unit with supplies. The rationale for the request was not provided for review. The Request for Authorization was submitted and dated 11/18/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS UNIT QTY : 1 FOR 30 DAY RENTAL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTRICAL NEUROSTIMULATION Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114, 116.

**Decision rationale:** The request for TENS unit for 30 day rental is not medically necessary. The injured worker complained of residual pain in his right thumb. He complained of right wrist pain which rated the pain 4/10 in severity which he described as constant, mild to moderate. The injured worker reported pain was aggravated by gripping, grasping, reaching, pulling and lifting. The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A 1 month home based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to programs of evidence-based functional restoration. The guidelines recommend documentation of pain of at least 3 months duration. The guidelines recommend evidence that other appropriate pain modalities have been tried including medication and failed. There is lack of documentation indicating that other appropriate pain modalities have been tried and failed. There is lack of documentation indicating significant deficit upon the physical exam. The injured worker's previous course of conservative care was not provided. Therefore, the request for TENS unit for 30 day rental is not medically necessary.

**SUPPLY (MONTHS) QTY: 2.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Transcutaneous Electrical Neurostimulation (TENS) Page(s): 114.

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

**Decision rationale:** Since the primary equipment is not medically necessary, none of the associated equipment is medically necessary.