

<b>Case Number:</b>	CM14-0155873		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	07/27/2011
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2014

### 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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 35 year old male who sustained an industrial injury on 07/27/2011. The mechanism of injury was he was struck by a falling pipe while wearing a hard hat and sustained a closed head injury, left scapula fracture, left shoulder fracture, 5 left-sided rib fractures and 4 vertebrae fractures. He continues to complain of neck, left shoulder and low back pain with associated bilateral leg weakness. The only documentation of objective physical findings is "complains of headaches, dizziness and difficulty sleeping"- all subjective complaints. Treatment has included medications, chiropractic care and acupuncture. The treating provider has requested rental of a stimulation unit and supplies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Rental: Stimulation Unit & Supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-115.

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

**Decision rationale:** The requested TENS is not medically necessary. Per California MTUS Guidelines it is not recommended as an isolated therapeutic intervention and is only

recommended on a one-month trial if it is part of a comprehensive rehabilitation program. There is no documentation indicating that the claimant is part of such a rehabilitation program. There is no report of functional benefit from electrical stimulation under the supervision of a licensed physical therapist. There is no specific documentation of a clinical condition for which use of this device is medically necessary. Medical necessity for the requested item has not been established. The requested treatment is not medically necessary.