

Case Number:	CM13-0010935		
Date Assigned:	11/08/2013	Date of Injury:	08/21/2011
Decision Date:	09/03/2014	UR Denial Date:	08/01/2013
Priority:	Standard	Application Received:	08/14/2013

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 and Rehabilitation and is licensed to practice in California. 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 54-year-old male who reported an injury on 08/21/2011. The mechanism of injury was not stated. The current diagnosis is sprain/strain of the shoulder and upper arm. It is noted that the injured worker is status post left shoulder rotator cuff repair. The latest physician progress report submitted for this review is documented on 06/26/2013. The injured worker reported left shoulder pain. The current medication regimen includes Norco 10/325 mg. The physical examination on that date revealed 165 degrees forward flexion, 120 degrees abduction, 40 degrees external rotation, normal rotator cuff strength, mild subacromial crepitus, and mildly positive impingement sign. Treatment recommendations included continuation of the current physical therapy program.

IMR ISSUES, DECISIONS AND RATIONALES

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

MONTHLY TENS UNIT SUPPLIES: ELECTRODES 8 PAIR BATTERIES 6 PAIRS FOR LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines RANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: The California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1-month home-based trial may be considered as a noninvasive conservative option. There is no documentation of this injured worker's current utilization of a TENS unit. Therefore, the medical necessity for monthly TENS unit supplies has not been established. As such, the request is not medically necessary and appropriate.