

Case Number:	CM13-0015939		
Date Assigned:	01/10/2014	Date of Injury:	03/14/2011
Decision Date:	08/12/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/23/2013

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 47-year-old female with a reported injury date on 03/14/2011; the mechanism of injury was related to slip and fall. Her diagnoses include partial tear of the rotator cuff and painful joint of the lower extremity. The latest clinical note dated 08/02/2013 revealed that the injured worker had multiple complaints to include pain in the back, right knee, and right shoulder. It was noted that the injured worker reported her right knee pain had been increasing. The pain was rated 4/10 to 5/10 at rest and 10/10 with activity. In addition, it was noted the injured worker had continued complaints of right shoulder pain radiating to the elbow with associated numbness in the right fingers. The injured workers current pain regiment which was noted to include Tramadol ER 150 mg was helpful in reducing her pain and function prior to flare-up, but currently, the pain had been severe. It was noted on physical examination that the injured worker ambulated without assistance, but did have an antalgic gait favoring the left lower extremity. It was noted there was no tenderness to palpation on the right knee and range of motion was painful with flexion. The McMurray's and negative drawer signs were negative. It was noted the injured worker refused to remove pants so the physician was unable to visualize the knee joint and assess for color changes or swelling. It was recommended in the treatment plan that the physician believed that the patient would benefit from TENS unit for future flare-ups. A request for authorization form was not provided in the documentation for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS UNIT: Upheld

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

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

Decision rationale: The California MTUS Guidelines do not recommend transcutaneous electrical nerve stimulation as a primary treatment modality, but a 1 month home-based TENS trial may be considered a non-invasive conservative option, if used as an adjunct to a program of evidence-based functional restoration if particular criteria are met. This criteria includes documentation of pain of at least 3 months, evidence other modalities have been tried and failed, and a treatment plan including specific short-term and long-term goals of treatment must be submitted. There is a lack of documentation showing that the patient has failed other conservative care treatments and there was no treatment plan provided within the documentation for review. Additionally, there was a lack of documentation provided showing the patient would use this requested device as an adjunct to a Functional Restoration Program. Furthermore, there is a lack of documentation showing how long this requested device is going to be used for. As such, this request is not medically necessary.