

Case Number:	CM13-0020213		
Date Assigned:	10/11/2013	Date of Injury:	11/10/2007
Decision Date:	01/17/2014	UR Denial Date:	08/29/2013
Priority:	Standard	Application Received:	09/04/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & 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 physician 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 patient is a 55-year-old female with a reported date of injury on 11/10/2007; the mechanism of injury was a fall. The patient presented with severe neck and right upper extremity pain and headaches, severe right scalene tenderness, right brachial plexus Tinel's, positive right costoclavicular abduction test, dysesthesia in the right C8-T1 dermatome, painful cervical spine range of motion, right trapezius hypertonicity, right parascapular pain, moderate right piriformis tenderness, and hypertonicity with positive right FAIR. The patient presented with a negative straight leg raise and a negative Lasegue's. The patient presented with diagnoses including status post left arthroscopic shoulder decompression in 2011, status post right arthroscopic rotator cuff repair, 11/2012, right thoracic outlet syndrome with associated right piriformis syndrome, right carpal tunnel syndrome, and right vascular headaches, and C4-5 disc herniation with stenosis and right C4-5 radiculopathy by EMG. The physician's treatment plan consisted of a request for 12 electrodes, per pair, between 07/28/2013 and 07/28/2013, and a request for 1 conductive gel or paste between 07/28/2013 and 07/28/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 electrodes, per pair DOS: 7/28/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Transcutaneous electrotherapy Page(s): 114-116.

Decision rationale: The California MTUS guidelines recommend the use of electrical stimulation for patients with neuropathic pain, CRPS II, Phantom limb pain, spasticity, and multiple sclerosis. The guidelines note criteria for the use of TENS include; chronic intractable pain (for the conditions noted above), documentation of pain of at least three months duration; there is evidence that other appropriate pain modalities have been tried (including medication) and failed; a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; other ongoing pain treatment should also be documented during the trial period including medication usage; and a treatment plan including the specific short and long-term goals of treatment. Within the provided documentation, the requesting physician's rationale for the request, as well as the efficacy of the therapy, was unclear. Additionally, within the provided documentation, there was a lack of documentation detailing the specific therapy the patient was receiving. Therefore, the request for 12 electrodes, per pair, between 07/28/2013 and 07/28/2013, is neither medically necessary nor appropriate.

1 conductive gel or paste DOS: 7/28/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Transcutaneous electrotherapy Page(s): 114-116.

Decision rationale: The California MTUS guidelines recommend the use of electrical stimulation for patients with neuropathic pain, CRPS II, Phantom limb pain, spasticity, and multiple sclerosis. The guidelines note criteria for the use of TENS include; chronic intractable pain (for the conditions noted above), documentation of pain of at least three months duration; there is evidence that other appropriate pain modalities have been tried (including medication) and failed; a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; other ongoing pain treatment should also be documented during the trial period including medication usage; and a treatment plan including the specific short- and long-term goals of treatment. Within the provided documentation, the requesting physician's rationale for the request, as well as the efficacy of the therapy, was unclear. Additionally, within the provided documentation, there was a lack of documentation detailing the specific therapy the patient was receiving. Therefore, the request for 1 conductive gel or paste, between 07/28/2013 and 07/28/2013, is neither medically necessary nor appropriate.