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| Case Number: | CM13-0021738 | | |
| Date Assigned: | 06/06/2014 | Date of Injury: | 12/27/2012 |
| Decision Date: | 07/12/2014 | UR Denial Date: | 08/28/2013 |
| Priority: | Standard | Application Received: | 09/06/2013 |

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 Neurological Surgery 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:

Let the records reflect that this 33-year-old male sustained an injury on 12/27/2012. The mechanism of injury indicates that the claimant was struck in the head and right shoulder by a metal door which fell down from above. There are on-going complaints of neck pain, headaches and right shoulder pain. A physical exam documented in the progress notes from 2013 to 2014 demonstrated tenderness to palpation at the occipital scalp region, acromioclavicular joint (AC) joint, subacromial space and rotator cuff tendon attachment sites. Right shoulder range of motion was decreased with a positive Hawkins and Neer's test. Sensation was intact to the upper extremities bilaterally. Motor strength decreased due to right upper extremity due to pain. Deep tendon reflexes were 2+ and symmetrical in the upper extremity. An MRI of the right shoulder, dated 7/8/2013 and 1/21/2014, demonstrated partial tears of the supraspinatus, infraspinatus and biceps tendon with an anterior labral tear, ganglion cysts at the greater tuberosity attachment of the transverse humeral ligament and acromioclavicular joint osteoarthritis. Electrodiagnostic test, such as an electromyography/nerve conduction velocity (EMG/NCV) dated 6/12/2013 indicates that the findings suggested of the chronic right C6 and chronic left C6-C7 radiculopathy. The diagnoses include: Headaches status post head trauma, post-traumatic right shoulder osteoarthritis with tenosynovitis, right biceps tendon injury and right anterior labral tear. Previous treatments have included physical therapy, chiropractic care, shoulder shockwave therapy for the shoulder, and medications. Right shoulder arthroscopy has been recommended. A request has been made for a TENS/EMS Unit and two (2) months of supplies to include electrodes, batteries, and lead wires. The non-medical necessity, dated 8/28/2013, appears to be based on lack of documentation of a one-month trial and clinical outcomes.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE (1) TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION/ELECTRICAL MUSCLE STIMULATION (TENS/EMS) UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The Chronic Pain Guidelines support the use of a Transcutaneous Electrical Nerve Stimulation (TENS) unit in certain clinical settings of chronic pain as a one (1) month trial when used as an adjunct to a program of evidence-based functional restoration for certain conditions and for acute postoperative pain in the first thirty (30) days following surgery. Based on the evidence-based trials, there is no support for the use of a (TENS) unit as a primary treatment modality. The record provides no documentation of an ongoing program of evidence-based functional restoration. In the absence of such documentation, this request does not meet guideline criteria for a TENS trial. As such, this request is considered not medically necessary.

SUPPLIES FOR TENS UNIT, INCLUDING ELECTRODES, BATTERIES AND LEAD WIRES FOR TWO (2) MONTHS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary request is not medically necessary, none of the associated services are medically necessary.