

Case Number:	CM13-0028701		
Date Assigned:	11/27/2013	Date of Injury:	06/11/2009
Decision Date:	01/23/2014	UR Denial Date:	08/26/2013
Priority:	Standard	Application Received:	09/25/2013

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 Family Practice, and is licensed to practice in Texas. 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 forty four year old male who reported an injury on 06/11/2009. The patient is currently diagnosed with a sprain of the sternoclavicular joint and a sprained shoulder/trapezius muscle/lateral epicondylitis of the elbow. The patient was recently seen by [REDACTED] on 08/05/2013. The patient complained of persistent pain in the left elbow and left sternoclavicular joint. Physical examination revealed positive tenderness of the left sternoclavicular joint, prominence over sternoclavicular joint, tenderness of the left acromioclavicular joint, tenderness of the left trapezius, limited left shoulder range of motion, pain with resisted shoulder abduction and flexion, tenderness over the lateral epicondyle, increased pain with wrist extension, 5/5 strength in the bilateral hands, wrists, and elbows, and inconsistent sensation in the left upper extremity. Treatment recommendations included continuation of current medications, therapeutic massage therapy, heating pad, and a TENS unit.

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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-120.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a one month home-based TENS trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. There should be documentation of pain at least 3 months in duration and evidence that other appropriate pain modalities have been tried and failed. As per the clinical notes submitted, [REDACTED] also requested a TENS unit in 03/2013. It is unknown whether the patient utilized a TENS unit between 03/2013 and 08/2013 prior to the second request. A treatment plan including the specific short-term and long-term goals of treatment with the TENS unit was not submitted for review. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.