

Case Number:	CM13-0029461		
Date Assigned:	11/01/2013	Date of Injury:	11/04/2003
Decision Date:	06/13/2014	UR Denial Date:	09/18/2013
Priority:	Standard	Application Received:	09/26/2013

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 Internal Medicine, has a subspecialty in Cardiology and is licensed to practice in Maryland and 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 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 patient is a 45 year old female who reported an injury on 06/03/1999 for the left shoulder, 05/26/2000 for the neck, left shoulder and left hand and 11/04/2003 for the neck, left shoulder, temporomandibular joint. The mechanism of injury was not submitted. The patient was diagnosed with chronic neck pain with multilevel degenerative disc disease and protrusion, status post left shoulder arthroscopy with distal clavicle excision, left elbow strain/sprain, cervical musculoligamentous sprain/strain with left upper extremity radiculitis with multilevel disc bulging with unvertebral osteophytes and central and foraminal stenosis confirmed with MRI, history of gout, sub-clinical Guyon's canal syndrome and carpal tunnel syndrome, complaints of headaches and depression, anxiety and difficulty sleeping. The patient continued to complain of pain and decreased range of motion. The patient has been treated with surgery, physical therapy, medication, injections, and electrodiagnostic studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

(8) ELECTRODES PAIRS: 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): 116.

Decision rationale: The clinical documentation submitted for review does not meet the guideline recommendations. The patient reported pain to this left shoulder, neck, left hand and face and has been treated with surgery, physical therapy, medication, injections, and electrodiagnostic studies. Chronic Pain Medical Treatment Guidelines states that documentation of pain of at least three months duration there and evidence that other appropriate pain modalities have been tried (including medication) and failed to for TENS. There was no objective clinical documentation submitted to show the efficacy of the patient's pain medication or functional deficits. Also, the request does not specify what type of machine for the 8 electrode pairs. As such, the request is not medically necessary.

(12) REPLACEMENT BATTERIES: 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): 116.

Decision rationale: The clinical documentation submitted for review does not meet the guideline recommendations. The patient reported pain to this left shoulder, neck, left hand and face and has been treated with surgery, physical therapy, medication, injections, and electrodiagnostic studies. Chronic Pain Medical Treatment Guidelines states that documentation of pain of at least three months duration there and evidence that other appropriate pain modalities have been tried (including medication) and failed for transcutaneous electrotherapy. There was no objective clinical documentation submitted to show the efficacy of the patient's pain medication or functional deficits. Also, the request does not specify the type of machine for the 12 replacement batteries. As the patient does not qualify for a TENS units, the batteries are not needed, therefore is not medically necessary.

(16) ADHESIVE REMOVER WIPES: 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): 116.

Decision rationale: The clinical documentation submitted for review does not meet the guideline recommendations. The patient reported pain to this left shoulder, neck, left hand and face and has been treated with surgery, physical therapy, medication, injections, and electrodiagnostic studies. Chronic Pain Medical Treatment Guidelines states regarding TENS units that documentation of pain of at least three months duration there and evidence that other appropriate pain modalities have been tried (including medication) and failed. There was no objective clinical documentation submitted to show the efficacy of the patient's pain medication or functional deficits. Also, the request does not specify the type of machine for the 16

adhesive removers. As the patient does not qualify for a TENS units, the request for 16 adhesive removers is not needed and therefore is not medically necessary.