

Case Number:	CM13-0034320		
Date Assigned:	12/06/2013	Date of Injury:	01/25/2010
Decision Date:	02/28/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/15/2013

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 Internal Medicine and Cardiology, has a subspecialty in Cardiovascular Disease 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 59-year-old female who reported an injury on 01/25/2010 due to a fall causing injury to her low back and bilateral wrists. The reported injury ultimately resulted in L4-5 fusion followed by hardware removal. The patient's left shoulder pain continued and failed to respond to physical therapy and acupuncture. The patient's most recent physical examination findings included restricted range of motion of the left shoulder described as 90 degrees in flexion, 90 degrees in abduction, 90 degrees in external rotation, and 90 degrees in internal rotation. The patient had a painful arc of the left shoulder and tenderness to palpation of the acromioclavicular joint. Evaluation of the lumbar spine revealed restricted range of motion secondary to pain and decreased sensation to light touch in the left lower extremity. The patient's diagnoses included grade 2 spondylolisthesis at the L4-5, left rotator cuff tendinopathy and subacromial impingement, left acromioclavicular arthritis, cervical spondylosis, and probable bilateral carpal tunnel syndrome. The patient's treatment recommendations included arthroscopic surgery of the left shoulder with continued pain management of the low back.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of a Replacement TENS Unit + Supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) for Pain, TENS, Chronic Pain.

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

Decision rationale: The Physician Reviewer's decision rationale: The requested replacement TENS unit for purchase plus supplies is not medically necessary or appropriate. The clinical documentation submitted for review does not provide any recent evidence that the patient has used a TENS unit in the management of the patient's pain. The request as it is written indicates that this is for a replacement unit. However, the efficacy of the prior unit is not established within the documentation submitted for review. There is no evidence of increased function or pain relief related to the use of the prior unit. Therefore, the purchase of an addition unit would not be indicated. As such, the replacement TENS unit for purchase plus supplies is not medically necessary or appropriate.