

<b>Case Number:</b>	CM13-0037676		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	10/07/2009
<b>Decision Date:</b>	02/13/2014	<b>UR Denial Date:</b>	10/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/24/2013

### 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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 66-year-old female who reported an injury on 10/07/2009. The patient is diagnosed with right shoulder rotator cuff tear, right shoulder subacromial bursitis, right shoulder impingement, right shoulder humeral head cyst, right elbow lateral epicondylitis, right hand carpal tunnel syndrome, myelopathy, multilevel herniated nucleus pulposus in the cervical spine, cervical radiculopathy, chronic mid back complaints, and obstructive sleep apnea. The patient was seen by [REDACTED] on 09/05/2013. The patient reported 7-8/10 pain. Physical examination revealed antalgic gait, tenderness to palpation in the cervical and thoracic paraspinals with spasm, right trapezius spasm, decreased range of motion in all planes, decreased sensation in the right C5 through C8 dermatomes, tenderness to palpation over the right shoulder with decreased range of motion, decreased strength, and hyperreflexic upper and lower extremities with positive Hoffmann's testing bilaterally. Treatment recommendations included continuation of current medications, interlaminar epidural steroid injection, and a 30-day trial of a TENS unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of a transcutaneous electrical nerve stimulator unit with HAN:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Transcutaneous electrotherapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 117-121.

**Decision rationale:** The California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 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. As per the clinical notes submitted, there is no indication of a successful 1 month trial period of a TENS unit. There is no documentation of how often the unit was used, outcomes in terms of pain relief and function, or medication usage. There is also no evidence of a treatment plan including the specific short and long-term goals of treatment with the TENS unit. Based on the clinical information received, the request for purchase of transcutaneous electrical nerve stimulator unit with HAN is non-certified.

**Three months supply of batteries (6 units per month):** 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 procedure is not medically necessary, none of the associated services are medically necessary.

**Three months supply of electrodes (8 pair per month):** 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 procedure is not medically necessary, none of the associated services are medically necessary.