

<b>Case Number:</b>	CM14-0104363		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	12/03/2012
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	06/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2014

### 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 Occupational Medicine 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:

The injured worker is a male with date of injury 12/3/2012. Per the primary treating physician's progress report dated 5/12/2014, the injured worker complains of pain and discomfort in the left shoulder with radiating pain to cervical spine. He is still complaining of pain in the lumbar spine that he describes as aching in nature with associated numbness radiating to the bilateral legs. He notes that his left knee and left hip pain is slightly improving. He rates his pain at 8/10. On examination there is tenderness to palpation of the right shoulder ant the middle portion, and of the left shoulder at the long head of biceps, anterior portion, and middle portion. Neer's test is positive on the left. Anterior apprehension test is positive on the left. Left shoulder range of motion is reduced in all planes. Motor strength is graded 4/5 with flexion, abduction, and external rotation of the left shoulder. He did have temporary relief from steroid/anesthetic injection on the left. Diagnoses include 1) cervical spine strain, resolved 2) thoracic spine strain, resolved 3) sprain/strain, left shoulder and arm 4) supraspinatus tendinosis with partial tear, left 5) labral tear, left shoulder 6) rule out new and further pathology, left shoulder 7) right shoulder strain, compensatory injury 8) musculoligamentous sprain/strain, lumbar spine 9) sprain/strain, left hip, resolved 10) sprain/strain, left knee, resolved.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**■■■■■ Infrared Heating Pad: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 44, 48, 49, 173, 174, 181, 203, 204, 212, 265, 271, 288, 299, 300, 308, 312, 338, 362, 369, 370.

**Decision rationale:** The MTUS Guidelines recommends the use of heat as an option for many musculoskeletal injuries. Passive modalities, including heat application, can be done without prescription, without a therapist, and without special equipment in a self-application at home. The use of heat may be used prior to exercise. The purchase of durable medical equipment for the application of heat is not consistent with the recommendations of the MTUS Guidelines. The request for [REDACTED] Infrared Heating Pad is not be medically necessary.

**TENS Unit [REDACTED] Stim:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <http://www.odg.twc.com/odgtwc/low-back/htm>

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

**Decision rationale:** The use of TENS for chronic pain is not recommended by the MTUS Guidelines as a primary treatment modality, but a one-month home-based TENS trial may be considered if used as an adjunct to a program of evidence-based functional restoration in certain conditions, which include neuropathic pain, phantom limb pain and CRPS II, spasticity, and multiple sclerosis. The criteria for the use of TENS include 1) documentation of pain of at least three months duration 2) evidence that other appropriate pain modalities have been tried (including medication) and failed 3) a one month trial period of TENS unit is documented with how much the unit was used as well as outcomes in terms of pain relief and function 4) other ongoing pain treatment is documented during the trial period including medication usage 5) there is a treatment plan including specific short and long term goals of treatment with the TENS unit, and 6) a 2-lead unit is used over a 4-lead unit unless there is documentation of why a 4-lead unit is necessary. The injured worker may have neuropathic pain, but the criteria recommended by the MTUS Guidelines to support the use of TENS are not met. Medical necessity has therefore not been established. The request for TENS Unit [REDACTED] Stim is not be medically necessary.