

Case Number:	CM14-0011799		
Date Assigned:	06/11/2014	Date of Injury:	10/16/2013
Decision Date:	07/14/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	01/29/2014

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 Physical Medicine & Rehabilitation, 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 26 year old male who reported an injury on 10/16/2013 due to a fall. On 12/19/2013 he reported having 8/10 right shoulder pain with weakness and spasm of the right cervical trapezius/deltoid. Physical exam revealed tenderness at the right shoulder anterior aspect with abduction at 90 degrees and forward flexion at 100 degrees, and diffuse right upper extremity decrease motor strength of 4/5 with diminished sensation diffuse. Diagnoses included right shoulder, rule out impingement/ rotator cuff pathology and rule out brachial plexus injury of the right upper extremity. Past treatments included medication and TENS. Medications included tramadol, anaprox, and protonix. The treatment plan was for E0730 TENS device 4/more leads mx nerve stimulation A4556 electrodes, per pair A4557 lead wires, per pair A4630 replace battery when necessary. The request for authorization and rationale were not included in the documentation for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR E0730 TENS DEVICE 4/MORE LEADS MX NERVE STIMULATION A4556 ELECTRODES, PER PAIR A4557 LEAD WIRES, PER PAIR A4630 REPLACE BATTERY MED NECESSARY (TENS PT OWN), 12/19/2013-12/19/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS CHRONIC PAIN Page(s): 114, 116.

Decision rationale: The request for a TENS device with 4/more leads, nerve stimulation electrodes, per pair lead wires, and per pair replace battery is non-certified. The injured worker reported an 8/10 shoulder pain. However, California MTUS Guidelines do not recommend the use of TENS as a primary treatment modality, but a 1 month trial may be considered if used as an adjunct to a program of evidence based functional restoration. There is no documentation stating that the injured worker was enrolled in an adjunct program. In addition, California MTUS guidelines criteria for the use of TENS including documentation of pain of at least 3 months, a one month trial period should be documented with an adjunct program stating pain relief and function, and a 2-lead unit is generally recommended; if a 4-lead unit is recommended there must be documentation of its necessity. The injured worker's pain relief and functional improvement was not provided in the documentation. In addition, the rationale for the need of a 4-lead unit is not stated. Furthermore, the injured worker did not have complaints of pain for 3 months prior to the request. As such, the request is non-certified.