

<b>Case Number:</b>	CM14-0111952		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	07/12/2004
<b>Decision Date:</b>	10/02/2014	<b>UR Denial Date:</b>	07/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2014

### 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 Anesthesiology, has a subspecialty in Pain Management 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 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 62 year old male who reported an injury on 07/12/2004. The mechanism of injury occurred when the injured worker was struck by an automobile. The injured worker had diagnoses including cervical radiculopathy, lumbar discogenic disease with radiculopathy and left shoulder impingement syndrome. Prior treatment included a facet joint injection. Diagnostic studies included an MRI of the Lumbar Spine which was performed on 11/22/2013, an MRI of the cervical spine which was performed on 11/21/2013, and an MRI of the left shoulder which was performed on 11/21/2013. The injured worker underwent left shoulder arthroscopic surgery. The injured worker complained of pain to the neck and left shoulder. The clinical note dated 04/24/2014 noted the left shoulder was healed with regards to the prior surgery. Forward flexion and abduction were 170 degrees, internal and external rotation was 70 degrees, and adduction and extension were 30 degrees. Impingement sign was positive. There was tenderness to palpation over the acromioclavicular joint. The injured worker had decreased painful range of motion to the cervical spine. The injured worker had muscle spasms, tenderness to palpation over the facet joint, and pain with axial compression. Medications included Norco. The treatment plan included a request for 8 month rental of transcutaneous electrical nerve stimulation unit for neck, upper extremities, and right ankle. The rationale for the request was to lessen his pain and improve his function particularly ranges of motion of neck, upper extremities and the right ankle. The request for authorization was not provided within the medical records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**8 Month Rental of Transcutaneous Electrical Nerve Stimulation Unit for Neck, Upper Extremities, and Right Ankle: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION Page(s): 114-116.

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

**Decision rationale:** The injured reported neck pain which radiated to the left arm rated 3/10 which increased with activity to 5-6/10. The California MTUS guidelines note TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The guidelines recommend the use of electrical stimulation for patients with neuropathic pain, CRPS II, Phantom limb pain, spasticity, and multiple sclerosis. The guidelines note there should be documentation of chronic intractable pain of at least three months duration with evidence that other appropriate pain modalities have been tried (including medication) and failed. The guidelines recommend a one-month home based trial of the TENS unit should be performed with documentation of how often the unit was used and outcomes in terms of pain relief and function. There is a lack of documentation indicating the injured worker has undergone a one month home based trial of the unit with documentation demonstrating the efficacy of the unit as well as detailing how often the unit was used after the injured worker underwent left shoulder arthroscopy. There is no indication that the unit is being requested as part of a rehabilitation program for specific short and long term goals. The requesting physician's rationale for the request for an 8 month rental is not indicated within the provided documentation. Therefore the request for 8 month rental of transcutaneous electrical nerve stimulation unit for neck, upper extremities, and right ankle is not medically necessary.