

Case Number:	CM14-0024426		
Date Assigned:	06/16/2014	Date of Injury:	08/27/2007
Decision Date:	07/29/2014	UR Denial Date:	01/29/2014
Priority:	Standard	Application Received:	02/26/2014

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 Emergency 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:

Patient with reported date of injury on 8/27/2007. Mechanism of injury reported from a fall from a ladder. Patient had unknown surgery after that original trauma. Patient then had bone infection of the affected shoulder requiring surgery to remove hardware and bone grafting. Patient has had 4 prior surgeries. Patient has a diagnosis of post removal of prior surgery hardware, loose glenoid and bone grafting, rotator cuff repair with continued weakness and stiffness. Multiple medical records from primary treating physician and consultants reviewed. Last report available until 4/8/14. Patient has complaints of R shoulder pain and weakness. Pain worsens with use. Objective exam reveals decreased active range of motion(ROM). Weakness with abduction and external rotation. Negative lift-off test and negative belly test. Mild impingement with end range flexion. Some atrophy noted in upper extremity. CT of right shoulder (8/17/12) reveals post-shoulder arthroplasty with lucency at bone interface of glenoid and post operative changes of proximal humerus. Degenerative changes of acromion. There is no medication list provided. Patient has completed multiple sessions of physical therapy. Utilization review is for Transcutaneous Electrical Nerve Stimulator(TENS) unit for 12month. Prior UR on 1/29/14 recommended modification to 1month trial. There is a note on 4/8/14 that TENS unit was still being used despite prior mention that it was only certified for 1month trial period.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS) UNIT TIMES TWELVE MONTHS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : CHRONIC PAIN MEDICAL TREATMENT, CHRONIC Page(s): 116.

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

Decision rationale: TENS or Transcutaneous Electrical Nerve Stimulation may help with pain but many studies are contradictory and evidence to support its use is poor. The original TENS prescription was a request for 12month use and was originally reviewed on 1/29/14. While TENS unit was used until 4/14, the continued use of the device and response to that treatment will not be considered for determination if the original UR request meets medical necessity. MTUS has specific criteria for use of TENS for either chronic pain or post-operative pain. Pt does not meet post-operative pain since MTUS recommends use only for first 30days post-operatively which patient is now outside that window period. For Chronic pain, MTUS has specific criteria: 1) Pain of at least 3months. Pt does not have any significant documented pain. There is no pain scale documented on record. Documentation does not meet criteria 2) 1month trial attempted. Does not meet criteria. Pt had not had a trial prior to the request for TENS 12month rental. 3) Prior ongoing treatment documented. Does not meet criteria. There is no provided medication list except for mention that patient is on opioids and that patient has completed multiple sessions of physical therapy. 4) Treatment plan. There is no treatment plan except to mention that TENS during physical therapy was "helping". Note mentions that there is a belief TENS may aid in strength and physical therapy. The patient does not meet any criteria for TENS use. Therefore, the request for transcutaneous electrical nerve stimulator (TENS) unit times twelve months is not medically necessary.