

<b>Case Number:</b>	CM14-0031492		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	03/24/2011
<b>Decision Date:</b>	07/17/2014	<b>UR Denial Date:</b>	03/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2014

### 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 and Rehabilitation, and is licensed to practice in Texas and New York. 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 46-year-old female who reported an injury on 03/24/2011. The mechanism of injury was not provided. The injured worker underwent a right shoulder arthroscopic extensive scar debridement, subacromial intraarticular capsular releases, revision of subacromial decompression and injection of corticosteroids and manipulation under anesthesia on 10/24/2013 of the right shoulder. The treatments included physical therapy and medications. The injured worker underwent an epidural steroid injection at the level of L5-S1 with an epidurogram on 10/16/2013. The documentation of 10/17/2013 revealed the injured worker had low back pain. The diagnosis included shoulder pain and spinal and lumbar degenerative disc disease (DDD) as well as low back pain. The treatment plan included medications, exercising, a home exercise program, and return for followup. There is no Division of Workers' Compensation (DWC) Form, Request for Authorization (RFA), nor progress report submitted for the requested service.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE: TENS UNITS FOR DATE OF SERVICE (DOS): 10/7/2013, QTY: 1:00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-115. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for the use of TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation Page(s): 114-116.

**Decision rationale:** The California MTUS recommends a one month trial of a transcutaneous electrical nerve stimulation (TENS) unit as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial, there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. In this case, the clinical documentation submitted for review failed to provide documentation of a Division of Workers' Compensation (DWC) Form, Request for Authorization (RFA), or progress report to support the requested service. The request as submitted failed to indicate whether the unit was for purchase or rental. Given the above, retrospective review for TENS unit for date of service 10/07/2013 is not medically necessary.

**RETROSPECTIVE: ELECTRICAL STIMULATOR SUPPLIES FOR DATE OF SERVICE (DOS): 10/7/2013, QTY: 1:00: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation Page(s): 114-116.

**Decision rationale:** As the requested transcutaneous electrical nerve stimulation (TENS) unit was found to be not medically necessary, none of the associated services (retrospective review for electrical stimulator supplies for date of service 10/07/2013) are medically necessary. As the requested TENS unit was found to be not medically necessary, the retrospective review for electrical stimulator supplies for date of service 10/07/2013 is not medically necessary.

**RETROSPECTIVE: REPLACEMENT BATTERIES FOR DATE OF SERVICE (DOS): 10/7/2013, QTY: 1:00: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation Page(s): 114-116.

**Decision rationale:** As the requested transcutaneous electrical nerve stimulation (TENS) unit was found to be not medically necessary, none of the associated services (retrospective review for replacement batteries for date of service 10/07/2013) are medically necessary.

**RETROSPECTIVE: LEADWIRES FOR DATE OF SERVICE (DOS): 10/7/2013, QTY: 1:00: Upheld**

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

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

**Decision rationale:** As the requested transcutaneous electrical nerve stimulation (TENS) unit was found to be not medically necessary, none of the associated services (retrospective review for lead wires for date of service 10/07/2013) are medically necessary.