

Case Number:	CM14-0045118		
Date Assigned:	07/02/2014	Date of Injury:	08/12/2010
Decision Date:	08/15/2014	UR Denial Date:	04/03/2014
Priority:	Standard	Application Received:	04/14/2014

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 patient is a 57-year-old female who sustained an injury on 08/12/2010. She sustained an injury while performing her usual and customary duties. She lifted a table and felt a sudden pop in her hip and felt immediate pain. The patient has been treated conservatively with acupuncture therapy and Toradol injection. The patient underwent a right shoulder arthroscopy in 01/2011. On internal medicine agreed medical evaluation (AME) report dated 11/15/2013, the patient was noted to have neck and shoulder problems. She is noted to have diagnoses including low back pain with underlying degenerative disk disease; right shoulder impingement, partial rotator cuff tear of the supraspinatus (PASTA) and labral tear status-post surgery, mild cervical strain with minimal disc bulge and hypertension with left ventricular hypertrophy. Progress report dated 03/27/2014 states the patient complained of low back pain and shoulder pain. There are no objective findings but refers to a letter of medical necessity which is not available for review. It is recommended the patient receive a transcutaneous electrical nerve stimulation (TENS) unit and supplies for home use to control pain. Prior utilization review dated 04/03/2014 states the request for a TENS unit for one month with supplies is denied as medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit for one month with supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation) Device Page(s): 114-7. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, TENS.

Decision rationale: According to MTUS guidelines, TENS may be indicated in the treatment of neuropathic pain, complex regional pain syndrome (CRPS), or spasticity. However, in this case records do not establish any of these conditions by history or examination. No diagnostic studies are provided. The patient has apparently used TENS in the past, but detailed outcomes are not provided. There does not appear to have been any clinically significant functional improvement from use of TENS, therefore medical necessity is not established.