

Case Number:	CM14-0050794		
Date Assigned:	07/07/2014	Date of Injury:	03/21/2012
Decision Date:	09/08/2014	UR Denial Date:	04/03/2014
Priority:	Standard	Application Received:	04/17/2014

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 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 injured worker is a 60 year old male injured on 03/21/12 due to undisclosed mechanism of injury. Current diagnoses included chronic reflex sympathetic dystrophy of the left upper extremity, history of comminuted telescoping fracture of the left long finger distal phalanx status post open reduction internal fixation on 04/03/12, previous traumatic subungual hematoma, bilateral cubital tunnel syndrome, bilateral carpal tunnel syndrome, left shoulder pain, depression and anxiety and cervical strain with radicular symptoms. Clinical note dated 03/17/14 indicated the injured worker presented complaining of pain, stiffness, weakness in the left hand, and pain in the left side of the neck and shoulder. The injured worker reported actively participating in therapy and reported difficulty raising his arm and worsening pain. Current medications include Norco 7.5mg Q six hours for shoulder and hand pain. Physical examination revealed inability to actively touch the fingers to proximal palm, no swelling or erythema, significant pain when passively flexing fingers, difficulty raising the shoulder above 60 degrees and tenderness in the left side of the neck and trapezius muscles but no significant swelling. Request for transcutaneous electrical nerve stimulation (TENS) unit to be used to left upper extremity three times a day and as needed for 3 months for pain control submitted. The injured worker also recommended continuing exercising two hours while awake, perform warm soaks and massage prior to exercising, and continue formal physical therapy. The initial request for durable medical equipment TENS (or equivalent) upper extremities left was initially non-certified on 04/03/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Durable Medical Equipment TENS (or equivalent) Upper Extremity Left: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, TENS.

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

Decision rationale: Criteria for transcutaneous electrical nerve stimulation (TENS) use includes documentation of pain of at least three months duration; evidence that other appropriate pain modalities have been tried (including medication) and failed; a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial; other ongoing pain treatment should also be documented during the trial period including medication usage; and a treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. These criteria are met based on clinical documentation and Division of Workers Compensation Form request for application review. As such, the request for durable medical equipment TENS (or equivalent) for upper extremity left is recommended as medically necessary.