

Case Number:	CM14-0061920		
Date Assigned:	07/11/2014	Date of Injury:	04/10/2008
Decision Date:	09/17/2014	UR Denial Date:	04/07/2014
Priority:	Standard	Application Received:	05/04/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 59-year-old male who reported an injury 07/01/2007. The mechanism of injury was not provided within the medical records. The clinical note dated 04/30/2014, indicate diagnoses of shoulder strain with rotator cuff tendinitis and a full thickness rotator cuff tear, crush injury on the right thumb/wrist with a history of fracture at the base of the right thumb, status post right thumb CMC arthroplasty dated 11/04/2010, right carpal tunnel syndrome per EMG/NCV dated 04/10/2009 and right wrist TFCC tear, left shoulder strain, biceps tendon rupture due to compensating for right upper extremity; MRI evidence of full thickness tear of the supraspinatus tendon; status post left shoulder arthroscopy rotator cuff repair, SAD, distal clavicular excision dated 06/21/2012. The injured worker reported he completed physical therapy for the right shoulder, which helped by 50%. The injured worker reported improvement in the left shoulder pain and reported he was pending surgery. On physical examination of the right shoulder, there was mild tenderness to palpation diffusely with range of motion revealing flexion of 160 degrees, abduction of 100 and internal rotation of 90 degrees and external rotation of 60 degrees with significant pain. There was tenderness over the proximal biceps. The examination of the left shoulder full range of motion with no tenderness noted and no pain with motion. The examination of the right wrist/hand revealed tenderness to palpation about the CMC joint of the thumb. There was weakness in grip strength. The injured worker's treatment plan included return to the orthopedic clinic for re-evaluation, schedule for surgery of the right thumb and prescription for medication. The injured worker's prior treatments included diagnostic imaging, surgery, physical therapy and medication management. The injured worker's medication regimen was not provided for review. The provider submitted a request for transcutaneous electrical nerve

stimulation device. A Request for Authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transcutaneous Electrical Nerve Stimulation device, Two lead, Localized E0720: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation) Transcutaneous electrotherapy.

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

Decision rationale: The request for Transcutaneous Electrical Nerve Stimulation device, two lead, Localized E0720 is not medically necessary. The California MTUS guidelines for the use of TENS unit requires chronic intractable pain documentation of at least a three month duration. There needs to be 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. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. Form-fitting TENS device: This is only considered medically necessary when there is documentation that there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment, that the patient has medical conditions (such as skin pathology) that prevents the use of the traditional system, or the TENS unit is to be used under a cast (as in treatment for disuse atrophy). There is lack of documentation indicating significant deficits upon physical examination. In addition, there was lack of evidence in the documentation provided that would indicate the need for the injured worker to have a TENS unit. Moreover, it was not indicated as to how the TENS unit would provide the injured worker with functional restoration. Additionally, it was not indicated if the injured worker had undergone an adequate TENS trial. Furthermore, the request did not indicate whether the injured worker needed to rent or purchase the TENS unit or for what body part the TENS unit was for. Therefore, the request for TENS unit is not medically necessary.