

Case Number:	CM14-0069333		
Date Assigned:	08/08/2014	Date of Injury:	09/12/2007
Decision Date:	09/23/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/14/2014

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 Physical Medicine and Rehabilitation and 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 60-year-old male who reported an injury on 09/12/2007. The mechanism of injury was not provided within the review. His diagnosis was noted to be rotator cuff tendinopathy. Diagnostic testing included an MRI. Prior therapy was medications. The injured worker was seen for a clinical evaluation on 03/20/2014. His subjective complaint was right shoulder pain. The objective findings included spasms in the right shoulder region musculature, right shoulder abduction, forward flexion and internal rotation were near normal and associated with discomfort at the end of range. The treatment plan was for a referral. A rationale for the request was not provided. A Request for Authorization form was also not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS 3 month supply: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation unit, and supplies.

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

Decision rationale: The request for TENS 3 month supply is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend TENS as a

primary treatment modality but a one month home based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence based functional restoration. The documentation provided does not indicate a functional restoration program as an adjunct to use with a 1 month home based TENS trial. Clinical documentation must note 3 months duration of pain. There must be evidence that other appropriate pain modalities have been tried and failed, including medications. The 1 month trial period TENS unit should be documented how often the unit was used, how well outcomes in terms of pain relief and function. Other ongoing pain treatments should also be documented during the trial period including medication usage. A treatment plan including 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 as to why this is a necessity. According to the documentation provided, and the criteria for the TENS unit according to the guidelines, the request for TENS 3 month supply is not medically necessary.

Electrodes QTY: 12 packs: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation unit, and supplies.

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services is medically necessary.

Battery Alkaline 9 volt QTY: 18: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation unit, and supplies.

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services is medically necessary.

Adhesive remover towel mint QTY: 24: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation unit, and supplies.

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services is medically necessary.

TENS lead wire QTY: 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation unit, and supplies.

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services is medically necessary.

Shipping and handling: 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
Page(s): 114-116.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services is medically necessary.