

Case Number:	CM14-0076195		
Date Assigned:	07/16/2014	Date of Injury:	11/23/2013
Decision Date:	08/14/2014	UR Denial Date:	04/25/2014
Priority:	Standard	Application Received:	05/22/2014

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 Texas. 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 sustained a work-related injury on 11/23/13 when she felt a slight pull from her upper extremities due to overexertion. Plain radiographs of the left shoulder dated 11/23/13 revealed soft tissue swelling over the elbow; however, there were no definite acute fractures or subluxations noted; joint spaces appear to be normal. A clinical note dated 12/09/13 reported that the injured worker continued to complain of pain in the left shoulder, elbow and arm, as well as the right wrist. Physical examination noted tenderness to palpation over the left trapezius/deltoid; shoulder range of motion flexion/abduction 150 degrees; tenderness to palpation along the lateral epicondyle; elbow range of motion from 0 to 135 degrees; grip strength 40/40/40 right wrist and 20/20/20 on the left. Treatment to date has included NSAIDs, physical therapy and activity restrictions. The injured worker continued to have pain that increases with overhead raising; she was diagnosed with left shoulder tendonitis and a right wrist sprain. The requested durable medical equipment was denied on 04/25/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Month Rental of Transcutaneous Electrical Nerve Stimulation Unit (TENS): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212, Chronic Pain Treatment Guidelines TENS Page(s): 116.

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 trial of TENS therapy for injured workers who are experiencing discomfort related to neuropathic pain, phantom limb pain, chronic regional pain syndrome (CRPS) II pain, spasticity and multiple sclerosis. Although the injured worker was noted to have spasms, guidelines state that the spasticity must be in relation to a spinal cord injury. The Chronic Pain Medical Treatment Guidelines states that while TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; and the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Several published evidence based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. Given this, the request for one month rental of Transcutaneous Electrical Nerve Stimulation unit (TENS) is not medically necessary and appropriate.

1 Hot and Cold Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, Continuous-flow cryotherapy.

Decision rationale: The Official Disability Guidelines states that other than at-home applications of ice packs or heating pads, guidelines state that continuous-flow cryotherapy, an actual unit is not recommended for non-surgical treatment. Without further information of the type of hot/cold unit being requested, guideline compliance cannot be established. After reviewing the submitted clinical documentation, there was no additional significant objective clinical information provided that would support reversing the previous adverse determination. Given this, the request for one hot and cold unit is not medically necessary and appropriate.