

<b>Case Number:</b>	CM14-0086998		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	05/09/2011
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	06/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/10/2014

### 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 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:

Injured worker is a 64-year-old-male with date of injury of 5/9/11. The mechanism of injury occurred when the patient hurt his left shoulder due to turning the steering wheel. He complains of pain and spasms in the left shoulder and left arm while performing duties as a bus operator. The patient had cortisone injection in November of 2011. On 10/01/2013 patient received ultrasound guided needle placement injection of Cortisone to Left shoulder subacromial space. Patient says last injections were very helpful. Patient continues to have tendinopathy and limitations with his shoulder and is not ready for surgery. Magnetic resonance imaging (MRI) of the left shoulder dated 7/13/11 has showed SLAP tear with focal calcification at the anchor and chronic wear of the posterosuperior labrum, marked overgrown degenerated acromioclavicular joint with mass effect in the cuff and bursa and there is chronic insertional tendinopathy of supraspinatus. Medications include Relafen and Lorazepam. Impression: Bilateral shoulder impingement syndrome with rotator cuff repair, Degeneration of Cervical Intervertebral disc, Late effects sprain/strain. Based on current available information, the medical necessity for a Combo TENS unit with HAN and lifetime monthly supplies (electrodes times 8 pairs, batteries times 6 units per month) has not been established, and therefore, the request is denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**████████████████████ Combo Transcutaneous Electrical Nerve Stimulation (TENS) Unit with HAN. Lifetime Monthly Supplies (Electrodes x8 Pairs; Batteries 6 Units Per Month: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**Decision rationale:** According to the California Medical Treatment Utilization Schedule (MTUS) guidelines, TENS for chronic pain, is recommended as a one-month home-based TENS trial which may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions such as: Neuropathic pain, Phantom limb pain, Spasticity, and Multiple sclerosis. The medical records do not document a reason for the requested Tens unit. There is no mention of specific need for the requested device. There is no documented neuropathic pain diagnosis to establish the need for the TENS unit. Based on the California (MTUS) guidelines and criteria as well as the clinical documentation stated above, therefore the request is not medically necessary.