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| Case Number: | CM15-0138672 | | |
| Date Assigned: | 07/28/2015 | Date of Injury: | 01/03/2003 |
| Decision Date: | 08/26/2015 | UR Denial Date: | 06/15/2015 |
| Priority: | Standard | Application Received: | 07/17/2015 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 61 year old female sustained an industrial injury to the right shoulder on 1/3/03. Documentation did not disclose recent magnetic resonance imaging or previous treatment. In a PR-2 dated 6/5/15, the injured worker complained of right shoulder with soreness and slight stiffness that was worse with overhead use. Physical exam was remarkable for reduced range of motion of the right shoulder with crepitation and acromial joint pain. Current diagnoses included acromioclavicular joint arthritis, shoulder subacromial bursitis and shoulder tendinitis. The treatment plan included requesting a transcutaneous electrical nerve stimulator unit, continuing daily exercises and Aspercream to the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME purchase of TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117 of 127.

Decision rationale: Regarding the request for TENS, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is not recommended 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 in the management of neuropathic pain, phantom limb pain, spasticity, and multiple sclerosis. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial 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. Within the documentation available for review, there is no indication that the patient has undergone a one-month TENS unit trial to treat a condition for which TENS is supported as outlined above. In the absence of clarity regarding those issues, the currently requested TENS unit is not medically necessary.

Aspercream 30mg qty 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: Regarding the request for Aspercreme, CA MTUS states that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Within the documentation available for review, none of the abovementioned criteria have been documented. Given all of the above, the requested Aspercreme is not medically necessary.