

<b>Case Number:</b>	CM15-0192033		
<b>Date Assigned:</b>	10/06/2015	<b>Date of Injury:</b>	02/11/2015
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2015

### 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

### 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 42-year-old female, with a reported date of injury of 02-11-2015. The diagnoses include shoulder sprain and strain, contracture of the upper arm joint, and headache. Treatments and evaluation to date have included physical therapy and Ibuprofen. The diagnostic studies to date have included an MRI of the left elbow on 03-26-2015 which showed mild changes of osteoarthritis in the elbow joint, minimal synovial effusion in the elbow joint, partial tear of the insertion of the brachialis tendon, subtle inter and intramuscular hyperintensity along the distal biceps muscle and the brachialis muscle in the distal arm as well as proximal forearm, which was suggestive of a strain, a small intramuscular fluid collection in the brachialis muscle, most likely representative of an intramuscular hematoma, and mild subcutaneous swelling around the elbow joint; and an MRI of the left arm on 03-27-2015. The progress report dated 09-17-2015 indicates that the injured worker presented for follow-up on the left upper extremity injuries. She continued to have left shoulder pain and decreased movement of the left elbow. It was noted that the injured worker had started two physical therapy sessions. The injured worker was currently not working. The doctor's first report dated 08-18-2015 indicates that the injured worker reported intermittent left biceps pain with weakness of her left arm, as well as difficulty extending at the elbow. The objective findings (09-17-2015) include a normal affect and active range of motion of the left elbow was 15-150 degrees. The treatment plan included the continued use of a TENS (transcutaneous electrical nerve stimulation) unit as needed. The treatment plan on 08-18-2015 included the return to the clinic in two weeks for a TENS trial. It was noted that although she had a TENS unit at home, she would undergo a trial to see if which

one was more beneficial for her. The injured worker's work status was changed to temporarily totally disabled. She has been instructed to remain off work until 10-29-2015. The request for authorization was dated 09-11-2015. The treating physician requested a TENS unit (indefinite use) and one Theracane. On 09-21-2015, Utilization Review (UR) non-certified the request for a TENS unit (indefinite use) and one Theracane.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**TENS (transcutaneous electrical nerve stimulation) unit, indefinite use, Qty 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** The patient presents with pain in the left shoulder, left forearm, and left elbow. The request is for TENS (Transcutaneous Electrical Nerve Stimulation) unit, indefinite use, qty 1. Physical examination to the left arm on 04/27/15 revealed tenderness to palpation to the brachioradialis. Patient's treatments have included medication, physical therapy, image studies, and acupuncture. Per 09/17/15 Request For Authorization form, patient's diagnosis include shoulder sprain strain, contracture upper arm joint, headache. Patient's medications, per 04/03/15 progress report include Tylenol and Ibuprofen. Patient is temporarily totally disabled. MTUS Chronic Pain Medical Treatment Guidelines, on page 116, Criteria For Use of TENS states the following: "(1) Documentation of pain of at least three months duration. (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed. (3) 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. (4) Other ongoing pain treatment should also be documented during the trial period including medication usage. (5) A treatment plan including the specific short- and long-term goals of treatment with the Tens unit should be submitted. (6). A 2-lead unit is generally recommended; if a 4-lead unit is recommended, MTUS recommends TENS for neuropathic pain, CRPS, Multiple Sclerosis, Phantom pain, and spasticity pain." In progress report dated 08/19/15, the treater states that the patient will return to the clinic in two weeks for TENS trial and although she has a TENS unit at home, she will undergo a trial to see which one is more beneficial for her. In this case, review of the medical records provided do not indicate prior one-month trial of TENS unit and its outcome, and there is no treatment plan with short and long term goals. MTUS requires documentation of one month prior to dispensing home units, as an adjunct to other treatment modalities, with a functional restoration approach. Furthermore, the treater has not indicated whether the requested Tens is for purchase or rental. Given the lack of documentation, as required by MTUS, the request is not medically necessary.

## **Theracane Qty 1: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute and Chronic) Chapter, under Home Exercise Kits.

**Decision rationale:** The patient presents with pain in the left shoulder, left forearm, and left elbow. The request is for Theracane qty 1. Physical examination to the left arm on 04/27/15 revealed tenderness to palpation to the brachioradialis. Patient's treatments have included medication, physical therapy, image studies, and acupuncture. Per 09/17/15 Request For Authorization form, patient's diagnosis include shoulder sprain strain, contracture upper arm joint, headache. Patient's medications, per 04/03/15 progress report include Tylenol and Ibuprofen. Patient is temporarily totally disabled. MTUS, ACOEM and ODG guidelines do not discuss the Theracane. The website, [www.theracane.com](http://www.theracane.com), the Theracane is a commercial product used by consumers/patient for self-trigger point massage and exercises. ODG Guidelines, Shoulder (Acute and Chronic) Chapter, under Home Exercise Kits stated: "Recommended. See Exercises, where home exercise programs are recommended; & Physical therapy, where active self-directed home physical therapy is recommended. In the RCT a specific shoulder home exercise program resulted in 69% good outcomes versus 24% in the sham exercise group, and 20% of patients in the specific exercise group subsequently chose to undergo surgery versus 63% in the control group. (Holmgren, 2012)" The term DME is defined as equipment which: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. The treater does not discuss this request or state the intended use of the Theracane. Theracane is a hand held cane shaped massager with six ball points. The non-mechanical massager allows the patient to self-use to apply pressure and massage muscles. The Theracane is a simple and cost effective tool for patients to self-massage. MTUS and ODG do support massage therapy as well as exercises. The request for Theracane is medically necessary.