

Case Number:	CM15-0203089		
Date Assigned:	10/19/2015	Date of Injury:	07/16/2015
Decision Date:	12/01/2015	UR Denial Date:	10/06/2015
Priority:	Standard	Application Received:	10/15/2015

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 53 year old female, who sustained an industrial injury on 7-16-2015. The injured worker is undergoing treatment for crush injury of fingers of the right hand, closed fracture of multiple sites of phalanges, post traumatic stress disorder (PTSD) and traumatic partial transpharengeal amputation of right finger. Medical records dated 8-24-2015 indicate physical therapy session 9 of 12 the injured worker "is making gains with swelling reduction, stump remodeling, desensitization and improved range of motion (ROM). Response to electrical stimulation to help with shoulder pain has been positive and it is recommended that patient have home unit to use on a throughout the day." Exam dated 8-27-2015 indicates the injured worker complains of right hand pain and right shoulder pain radiating from the hand. She reports Zoloft caused severe headaches and has stopped taking it. Physical exam dated 8-27-2015 notes wounds have healed well, No excessive tenderness to light touch of the fingers and the ability to slightly bend the fingers. There is no swelling of the right shoulder, decreased range of motion (ROM) and positive Hawkin's and Neer's test. Treatment to date has included physical therapy, medication. The treating physician on 8-27-2015 does not provide indication of a trial of Transcutaneous Electrical Nerve Stimulation (TENS) unit. The original utilization review dated 10-6-2015 indicates the request for outpatient purchase of one GSM HD combo TENS unit with HAN programs, electrodes 8 pair per month and batteries 6 units per month is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient purchase of one GSM HD combo TENS unit with HAN programs, electrodes 8 pair per month and batteries 6 units per month: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care, and Forearm, Wrist, and Hand Complaints 2004, Section(s): Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter: TENS (transcutaneous electrical nerve stimulation), Official Disability Guidelines (ODG), Pain Chapter: TENS, chronic pain (transcutaneous electrical nerve stimulation), Official Disability Guidelines (ODG), Forearm, Wrist and Hand Chapter: TENS (transcutaneous electrical nerve stimulation).

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

Decision rationale: Review indicates therapy report of 8/24/15 noting some positive response for shoulder pain and recommended a purchase for the requested unit for home use. Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain for diagnosis such as neuropathy or CRPS of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication, not demonstrated here for associated diagnosis of shoulder pain. There is no documentation on specific previous trial of benefit in terms of decreased VAS score, decreased pharmacological profile, decreased medical utilization, nor is there any documented short-term or long-term goals of treatment with the TENS unit from treatment rendered to support for the purchase of the unit. The Outpatient purchase of one GSM HD combo TENS unit with HAN programs, electrodes 8 pair per month and batteries 6 units per month is not medically necessary and appropriate.