

<b>Case Number:</b>	CM15-0032713		
<b>Date Assigned:</b>	02/26/2015	<b>Date of Injury:</b>	06/30/2009
<b>Decision Date:</b>	04/13/2015	<b>UR Denial Date:</b>	02/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/21/2015

### 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 male, who sustained an industrial injury on 06/30/2009. On provider visit dated 01/28/2015 the injured worker has reported left shoulder pain and stiffness of neck. The diagnoses have included bilateral shoulder pain and dysfunction, right shoulder partial rotator cuff tear, status post right shoulder A/S debridement SAD, status post left shoulder A/S with debridement of prior slap lesion suture, biceps tenotomy and subacromial decompression and cervical spinal strain. Treatment plan included left shoulder physical therapy, TENS unit for home use, and medication. On examination, the right shoulder was noted to have a limited and painful range of motion, tenderer cervical lumbar paraspinals and decreased range of motion, tender bilateral knees and positive McMurrays and tender bilateral elbow at joint line. On 02/11/2015 Utilization Review non-certified TENS two lead, unspecified if rental or purchase and duration. The CA MTUS, ACOEM, Chronic Pain Medical Treatment Guidelines, (or ODG) were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENs two lead, unspecified if rental or purchase and duration:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 114.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS  
Page(s): 114-116.

**Decision rationale:** The patient presents with pain and weakness in his neck, shoulder, lower back and lower extremity. The Patient is s/p left shoulder arthroscopy on 04/24/14 and right shoulder arthroscopy on 12/04/14. The request is for TENS TWO LEAD, UNSPECIFIED IF RENTAL OR PURCHASE AND UNSPECIFIED DURATION. Per MTUS Guidelines page 116, TENS unit have not proven efficacy in treating chronic pain and is not recommended as a primary treatment modality, but a 1-month home based trial may be consider for a specific diagnosis of neuropathy, CRPS, spasticity, phantom limb pain, and multiple scoliosis. When a TENS unit is indicated, a 30-home trial is recommended and with documentation of functional improvement, additional usage may be indicated. In this case, the patient has used TENS unit in the past, but there is no documentation showing how TENS was used and with what effectiveness. MTUS requires documentation of use and efficacy before a TENS unit is allowed for a home use. Furthermore, the request is not clear whether it is for rental or home purchase. Given the lack of documentation, the request IS NOT medically necessary.