

<b>Case Number:</b>	CM15-0040723		
<b>Date Assigned:</b>	03/10/2015	<b>Date of Injury:</b>	12/13/2012
<b>Decision Date:</b>	04/21/2015	<b>UR Denial Date:</b>	02/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2015

### 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 65-year-old male, who sustained an industrial injury on 12/13/2012. He reported that he was on a tractor, loosening up the oil drain plug, when it snapped. He reported bilateral shoulder pain. The injured worker was diagnosed as having other affections of shoulder region, not elsewhere classified. Treatment to date has included surgical (10/27/2014 right shoulder arthroscopy, manipulation and capsular release) and conservative treatments, including diagnostics, medications, and physical therapy. Currently, the injured worker complains of continued shoulder pain, rated 5/10, and unchanged. He completed 5/10 physical therapy sessions without improvement. Physical therapy progress notes were not submitted. Radiographic imaging results were not noted. Physical exam noted no swelling, normal sensation, motor strength 5/5, intact neurovascular status, range of motion full, and weakness of the rotator cuff. Medications included Norco. It was documented that he had a home transcutaneous electrical nerve stimulation unit, although use was not specified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS Unit & Supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of TENS. Decision based on Non-MTUS Citation Shoulder Complaints.

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

**Decision rationale:** This patient has a date of injury of 12/13/2012 and presents with residual right shoulder pain following a right shoulder arthroscopy, arthroscopic capsular release, and MUA on 10/27/2014. The medical file provided for review does not include a Request for Authorization form. The current request is for TENS unit and supplies. Per MTUS Guidelines page 116, TENS units have not proven efficacy in treating chronic pain and are not recommended as a primary treatment modality, but a 1-month home-based trial may be considered for specific diagnoses of neuropathy, CRPS, spasticity, phantom limb pain, and multiple sclerosis. When a TENS unit is indicated, a 30-day home trial is recommended and with documentation of functional improvement, additional usage may be indicated. The medical file provided for review includes no discussion regarding the requested TENS unit, and there is no Request for Authorization form. This appears to be an initial request. In this case, recommendation cannot be made as the treating physician has requested a TENS unit and supplies without specifying duration. When a TENS unit is indicated, a home 30-day trial is recommended first. The requested TENS unit IS NOT medically necessary.