

Case Number:	CM15-0082681		
Date Assigned:	05/05/2015	Date of Injury:	11/23/2011
Decision Date:	06/05/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	04/30/2015

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: Utah, Arkansas

Certification(s)/Specialty: Family Practice, Sports Medicine

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 77-year-old Male who sustained an industrial injury on 11/23/11. The injured worker reported symptoms in the neck, back, right shoulder left shoulder and left knee. The injured worker was diagnosed as having cervical sprain/strain, thoracic sprain/strain, lumbar sprain/strain, lumbar radiculitis, left shoulder sprain/strain, left rotator cuff tear, status post left shoulder surgery, left knee sprain/strain, left knee internal derangement and status post left knee surgery. Treatments to date have included shockwave treatments; status post left shoulder surgery, topical creams, oral pain medication, activity modification, physical therapy, status post left knee replacement surgery, rest, heat application, and physiotherapy. Currently, the injured worker complains of discomfort in the neck, back, right shoulder left shoulder and left knee. The plan of care was for a transcutaneous electrical nerve stimulation unit and supplies.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit and supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit, page(s) 113-115.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for TENS unit. MTUS guidelines state the following: Not recommended as a primary treatment modality. While TENS may reflect the long standing accepted standard of care within many medical communities, the results of studies are inconclusive, the published trials do not provide parameters, which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Several studies have found evidence lacking concerning effectiveness. A one-month trial may be considered for condition of neuropathic pain and CRPS, phantom limb, multiple sclerosis and for the management of spasticity in a spinal cord injury. The patient does not meet the diagnostic criteria at this time. According to the clinical documentation provided and current MTUS guidelines, A TENS unit is not medically necessary to the patient at this time.