

<b>Case Number:</b>	CM15-0086840		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	10/24/2008
<b>Decision Date:</b>	06/10/2015	<b>UR Denial Date:</b>	04/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/06/2015

### 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: New York

Certification(s)/Specialty: Internal 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 62 year old male who sustained an industrial injury on 10/24/2008. His diagnoses, and/or impressions, are noted to include: right and left shoulder rotator cuff tears, status-post surgical repair (6/27/09). No current imaging studies or x-rays are noted. His treatments have included surgery; physical therapy; a home exercise program; medication management; and permanent work restrictions. Progress notes of 1/8/2015 reported a follow-up of his bilateral shoulders with complaints of the inability to tolerate Nortriptyline and having stopped it in 12/2014, an inquiry about something different to control his left shoulder pain, and stating his preference to not have acupuncture. Objective findings were noted to include no acute distress; decreased flexion and abduction of the left shoulder with the ability for pendulum and assisted motion; and full motion of the right shoulder. The physician's requests for treatments were noted to include the purchase of a trans-cutaneous electrical nerve stimulation unit and six months of batteries, for the bilateral shoulders.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-121.

**Decision rationale:** According to the MTUS guidelines, the TENS unit is not recommended as a primary treatment modality. A one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for conditions such as, neuropathic pain, phantom limb pain, complex regional pain syndrome (CRPS), spasticity or multiple sclerosis (MS). In this case, the claimant had relief with use of the TENS but there is no documentation indicating that use of the TENS is part of a functional restoration program. Medical necessity for the requested item has not been established. The requested TENS Unit is not medically necessary.

**6 month supply of electrodes and batteries:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-121.

**Decision rationale:** The requested TENS unit has been determined not to be medically necessary. The requested 6 month supply of electrodes and batteries are not required. Medical necessity for the requested items is not established. The requested items are not medically necessary.