

<b>Case Number:</b>	CM15-0087660		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	09/05/2012
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	04/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 36 year old female, who sustained an industrial injury on 9/05/2012. She reported right shoulder pain and injury as a result of heavy lifting. Diagnoses include shoulder and upper arm strain, wrist sprain/strain, myofascial syndrome and severe depression. She is status post right rotator cuff SLAP repair in 2012. Treatments to date include NSAID, Ibuprofen, analgesic, physical therapy, massage, and cortisone injection. Currently, she complained of chronic right shoulder pain. Pain was rated 4-6/10 VAS and a previous electromyogram (EMG) study was negative. On 3/2/15 she underwent a multidisciplinary evaluation. The physical examination documented pain at the end of range of motion in the right shoulder. There was decreased strength on the right hand and muscle spasm about the shoulder girdle. The plan of care included a TENS unit for purchase.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit (purchase):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Transcutaneous electrotherapy Page(s): 114-117.

**Decision rationale:** TENS unit (purchase) is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. The guidelines state that a TENS unit can be used for neuropathic pain; CRPS; MS; spasticity; and phantom limb pain. The documentation does not clearly indicate functional improvement or evidence of significant pain relief/reduction in pain medications for prior TENS use therefore a TENS unit for purchase is not medically necessary.