

<b>Case Number:</b>	CM14-0124295		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	03/26/2002
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	07/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 72 year old female who reported a date of injury of 09/27/1999. The mechanism of injury was reported as a fall. The injured worker had diagnoses of impingement syndrome of the right shoulder, Colle's fracture of the right wrist and arthritis of the knees bilaterally. Prior treatments were not indicated within the medical records received. The injured worker had x-rays of unknown dates of the right shoulder, wrist, and the right and left knees of unknown dates. The official reports were not provided within the medical records received. Surgeries included an unspecified right shoulder surgery on 09/14/2010 and left total knee arthroplasty on 02/01/2010 and 01/30/2012. The injured worker had complaints of pain in the right wrist, shoulder, and the knees bilaterally. The clinical note dated 02/27/2014 noted the injured worker had mild pain and tenderness to palpation over the anterior aspect of the right shoulder. The motor strength, range of motion and deep tendon reflexes of the injured worker's right shoulder were within normal limits. The injured worker had global tenderness to palpation about the right wrist, her range of motion of the right wrist was normal and there was no evidence of intrinsic, thenar or hypothenar atrophy. The injured worker's left hand grip was 40/40/30. The injured workers knees bilaterally had global tenderness to palpation and her range of motion, motor strength, deep tendon reflexes and circulation of the knees bilaterally were within normal limits. The injured worker had a negative Patellar apprehension sign and Patellar grind test. Medications included Hydrocodone, Diclofenac Sodium and Cyclobenzaprine. The treatment plan included Hydrocodone, Diclofenac Sodium, Pantoprazole sodium and Cyclobenzaprine. The rationale and request for authorization form were not provided within the medical records received.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME Qty: 48 Electrodes: 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 Transcutaneous electrotherapy Page(s): 114-116.

**Decision rationale:** The request for DME Qty: 48 Electrodes is not medically necessary. The injured worker had complaints of pain in the right wrist, shoulder, and knees bilaterally. The California MTUS guidelines note the use of TENS is not recommended as a primary treatment modality. A one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for patients with neuropathic pain, CRPS II, CRPS I, spasticity, and/or multiple sclerosis. Prior to a one month trial the guidelines recommend there must be documentation of pain of at least three months duration and there should be evidence that other appropriate pain modalities have been tried (including medication) and failed. There is a lack of documentation which indicates the specific device which the supply is being requested for. There is a lack of documentation demonstrating the efficacy of the unit as well as detailed information of the frequency of use. There is a lack of documentation indicating the injured worker was issued a TENS unit or utilizing an adjunct program of evidence-based functional restoration. The requesting physician's rationale for the request is not indicated within the provided documentation. As such, the request is not medically necessary.

**VO IN RND N-S Qty: 144: 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 Transcutaneous electrotherapy Page(s): 114-116.

**Decision rationale:** As the primary request is not supported this associated service is also not medically necessary.

**Battery VO Pack AA Qty: 192: 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 Transcutaneous electrotherapy Page(s): 114-116.

**Decision rationale:** As the primary request is not supported this associated service is also not medically necessary.

**Adhesive Remover Wipes Qty: 1:** 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 Transcutaneous electrotherapy Page(s): 114-116.

**Decision rationale:** As the primary request is not supported this associated service is also not medically necessary.

**Electrodes Shipping cost, refill of 6 months of 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 Transcutaneous electrotherapy Page(s): 114-116.

**Decision rationale:** As the primary request is not supported this associated service is also not medically necessary.