

Case Number:	CM14-0125151		
Date Assigned:	08/11/2014	Date of Injury:	07/18/2013
Decision Date:	10/15/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	08/07/2014

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 Family 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 37 year old female who reported an injury on 7/18/13 to her right shoulder. A clinical note dated 07/11/14 indicated the injured worker complaining of right shoulder pain. The injured worker underwent rotator cuff repair in 02/14. The injured worker also reported neck pain. Upon exam, the injured worker demonstrated 170 degrees of flexion and abduction. The injured worker had positive Apley's scratch test. The utilization review dated 07/09/14 resulted in denial for continued use of electrical stimulation device as insufficient information was submitted supporting the request. A clinical note dated 05/30/14 indicated the injured worker utilizing Tramadol, Lidoderm patches, Naprosyn, and Ambien. The operative note dated 02/17/14 indicated the injured worker undergoing rotator cuff repair secondary to full thickness tear.

IMR ISSUES, DECISIONS AND RATIONALES

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

E-Stim: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines E-Stim.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Page(s): 114-121.

Decision rationale: The injured worker complained of ongoing right shoulder pain despite previous surgical intervention. The use of E stimulation device is indicated following a one month trial of a transcutaneous electrical nerve stimulation (TENS) unit. No information was submitted regarding response to previous one month trial of TENS unit. Furthermore, it is unclear if the injured worker has completed any recent conservative treatments addressing ongoing shoulder pain. Given this, the request is not indicated as medically necessary.