MAXIMUS Federal Services

Case Number:	CM14-0143529		
Date Assigned:	09/10/2014	Date of Injury:	06/09/2010
Decision Date:	10/10/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/04/2014

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 and Rehabilitation 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 48-year-old female who reported an injury on 06/09/2011 due to an unknown mechanism. Diagnosis was recent subacromial decompression of the right shoulder on 07/02/2014. Past treatments were medications, physical therapy, injections into the right shoulder. Diagnostic studies were MRI of the lumbar spine. The MRI revealed a 1.3 to 3 mm disc bulge at L4-5 and 1.3 to 1.9 mm disc bulge at L5-S1. Physical examination on 07/07/2014 revealed motor and sensation were intact. The shoulder was elevated to 120 degrees. There was moderate rotator cuff weakness. Medications were not reported. The treatment plan was for postoperative physical therapy. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pro-Stim (TENS) Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, NMES, Interferential Current Stimulation, Page(s): 114-116, 121, 118.

Decision rationale: The decision for Pro-Stim (TENS) Unit is not medically necessary. The California Medical Treatment Utilization Schedule recommend 1 month trial of TENS unit as an

adjunct to a program of evidence based functional restoration for chronic neuropathic pain. Prior to the trial, there must be documentation of at least 3 months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. The guidelines do not recommended neuromuscular electrical stimulation (NMES devices) as there is no evidence to support its use in chronic pain. The guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention. This request does not state whether this is for the 1 month trial use, rental or purchase. The rationale for the Pro-Stim Unit was not provided. The clinical information submitted for review does not provide evidence to justify certification for this request. Therefore, this request is not medically necessary.

Pro-Stim(TENS) Unit Supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, NMES, Interferential Current Stimulation Page(s): 114-116, 121, 118.

Decision rationale: The decision for Pro-Stim (TENS) Unit Supplies is not medically necessary. Due to the fact that the request for TENS unit is not medically necessary, this request is also not medically necessary.