

Case Number:	CM14-0176895		
Date Assigned:	10/30/2014	Date of Injury:	09/10/2012
Decision Date:	12/05/2014	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	10/24/2014

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 Connecticut. 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 62-year-old male who reported an injury on 09/10/2012. The mechanism of injury was not submitted for clinical review. The diagnoses included right shoulder full thickness supraspinatus tendon tear with 3.8 cm of retraction. The previous treatments included acupuncture, physical therapy, and medication. Diagnostic testing included an MRI. Within the clinical note dated 08/15/2014, it was reported the patient complained of pain rated 10/10. On the physical examination, the provider noted the shoulder range of motion was noted to be 90 degrees of forward flexion and 40 degrees of extension on the right. The provider noted the injured worker to have mild right shoulder bicep tenderness. There was tenderness to the right AC joint. There was decreased sensation in the entire right upper extremity. The provider noted the injured worker had a positive AC joint compression test, impingement test on the right shoulder. Request was submitted for a retrospective electrode gel/battery pack/adhesive remover wipe for existing TENS unit. However, a rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Electrode gel/Battery power pack/Adhesive remover wipe for existing E-Stim (TENS) for date of services (DOS) 8/22/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, TENS (transcutaneous electrical nerve stimulation).

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

Decision rationale: The retrospective request for electrode gel/battery power pack/adhesive remover wipe for existing E stim (TENS) for date of service 08/22/2014 is not medically necessary. The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A 1 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. There is evidence of appropriate pain modalities to have been tried and failed, including medication. There is lack of documentation indicating the injured worker has been utilizing a TENS unit. Additionally, the retrospective date of service was not submitted for clinical review. The treatment site for the use of the request was not submitted. There is lack of significant objective findings warranting the medical necessity for the request. Therefore, the request is not medically necessary.