

<b>Case Number:</b>	CM14-0215277		
<b>Date Assigned:</b>	01/02/2015	<b>Date of Injury:</b>	06/17/2013
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### 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. 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: California, Hawaii  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 patient is a 62 year old male with date of injury 06/17/13. The treating physician report dated 11/20/14 (32) indicates that the patient presents with pain affecting his left shoulder and neck. The physical examination findings reveal positive impingement and tenderness of the left shoulder with limited range of motion and tenderness in the neck. Prior treatment history includes left shoulder surgery and physical therapy. MRI findings reveal mild disc desiccation at C2-3 down to C6-7, mild disc extrusion with subligamentous hemiation at C3-4, C4-5, & C5-6, and a mild broad-based disc protrusion at C6-7. Current medications are Ultram and Naprosyn. The current work status is modified to no overhead lifting or pulling/pushing. The current diagnoses are: 1. Disc Protrusions- Cervical. 2. Adhesive Capsulitis (Frozen Shoulder). The utilization review report dated 12/01/14 denied the request for TENS Unit based on guidelines not being met (35).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit:** Upheld

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

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

**Decision rationale:** The patient presents with pain affecting his left shoulder and neck. The current request is for a TENS Unit. The treating physician states that the patient has frozen shoulder syndrome. The MTUS guidelines state, "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; rental would be preferred over purchase during this trial. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted." In this case, the treating physician has not documented if the patient has ever had a one month trial with a TENS unit and if so, how often the patient used the unit and if it provided any relief for the patient. The current request is not medically necessary and the recommendation is for denial.