

<b>Case Number:</b>	CM15-0116296		
<b>Date Assigned:</b>	06/24/2015	<b>Date of Injury:</b>	07/26/2011
<b>Decision Date:</b>	07/24/2015	<b>UR Denial Date:</b>	06/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2015

### 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  
 Certification(s)/Specialty: Emergency Medicine

### 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 56-year-old female, who sustained an industrial injury on 7/26/11. She has reported initial complaints of right hand and upper extremity injury. The diagnoses have included impingement syndrome, biceps tendinitis, and acromioclavicular joint (AC) joint arthritis. Treatment to date has included activity modifications, off work, diagnostics, surgery, injections, physical therapy, and other modalities. Currently, as per the physician progress note dated 5/19/15, the injured worker complains of right shoulder pain that is unchanged. She had a right biceps injection that helped her pain for about two weeks. She states that between therapy and everyday activities the pain has returned. She does not take any medications. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the right shoulder dated 9/17/14 that reveals tendinopathy of the rotator cuff, acromioclavicular joint (AC) arthropathy and degenerative changes. The physical exam of the right shoulder reveals slightly positive Neer's sign; she has slightly positive cross body adduction test, and slightly positive O'Brien's test. The previous physical therapy sessions are noted. The physician requested treatments included TENS (transcutaneous electrical nerve stimulation) unit 4 lead quantity of 1 and TENS (transcutaneous electrical nerve stimulation) unit, supplies (electrodes) quantity of 1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS (transcutaneous electrical nerve stimulation) unit, 4 lead, Qty 1:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

**Decision rationale:** As per MTUS Chronic pain guidelines, TENS (Transcutaneous Electrical Nerve Stimulation) may be recommended only if it meets criteria. Evidence for its efficacy is poor. Pt does not meet criteria to recommend TENS. TENS is only recommended for neuropathic or Complex Regional Pain Syndrome (CRPS) pain. Patient has a diagnosis of various shoulder and musculoskeletal pain. There is no documentation of failures of multiple conservative treatment modalities. Guidelines recommend use only with Functional Restoration program, which is not documented. There is no documentation of short or long-term goal of TENS unit. There is no documentation of an appropriate 1-month trial of TENS. MTUS also recommends rental over purchase, there is no documentation as to why a TENS unit needed to be purchased instead of rented. Patient fails multiple criteria for TENS purchase. TENS is not medically necessary.

**TENS (transcutaneous electrical nerve stimulation) unit, supplies (electrodes), Qty 1:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

**Decision rationale:** As per MTUS Chronic pain guidelines, TENS (Transcutaneous Electrical Nerve Stimulation) may be recommended only if it meets criteria. Evidence for its efficacy is poor. Pt does not meet criteria to recommend TENS. TENS is only recommended for neuropathic or Complex Regional Pain Syndrome (CRPS) pain. Patient has a diagnosis of various shoulder and musculoskeletal pain. There is no documentation of failures of multiple conservative treatment modalities. Guidelines recommend use only with Functional Restoration program, which is not documented. There is no documentation of short or long-term goal of TENS unit. There is no documentation of an appropriate 1-month trial of TENS. MTUS also recommends rental over purchase, there is no documentation as to why a TENS unit needed to be purchased instead of rented. Patient fails multiple criteria for TENS purchase. TENS is not medically necessary.