

Case Number:	CM15-0176600		
Date Assigned:	09/17/2015	Date of Injury:	05/23/2013
Decision Date:	10/20/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	09/08/2015

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: 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 injured worker is a 39-year-old female, with a reported date of injury of 05-23-2013. The diagnoses include chronic neck pain, chronic left shoulder strain, left shoulder partial rotator cuff tear, left shoulder impingement, left adhesive capsulitis (frozen shoulder), low back pain, chronic lumbar spine strain, and depression. Treatments and evaluation to date have included muscle relaxant, Tramadol, Lidocaine patches, Naproxen, Flector patch, acupuncture, and home exercises. The diagnostic studies to date have included physical therapy; and an MRI of the lumbar spine on 08-01-2014 with normal findings. The medical report dated 07-13-2015 indicates that the injured worker complained of neck pain with occasional radiation to the left periscapular region and left forearm; left shoulder pain; and low back pain with radiation to the lateral thigh to the third and fifth toes. The objective findings included tenderness to palpation and muscular hypertonicity of the suboccipital muscles bilaterally and left cervical paravertebral muscles; decreased cervical spine range of motion; positive left shoulder depression; a negative impingement sign in the left shoulder; decreased range of motion of the left shoulder; a walk with a limp favoring the left lower extremity; tenderness to palpation and muscular hypertonicity of the lumbar paraspinal muscles bilaterally and left piriformis muscle; decreased lumbar spine range of motion; positive straight leg raise test on the left. It was noted that the injured worker underwent an MRI of the left shoulder on 04-01-2014; and electrodiagnostic studies of the left upper extremity on 12-26-2014. The progress report dated 08-04-2015 indicates that the injured worker had left shoulder pain, back pain, and depression. The physical examination showed minimal to no tenderness of the left shoulder; good range of motion of the left shoulder; slight tenderness of the back centrally and laterally; slight decreased range of motion in the back due to pain; and slightly decreased strength in the back due to pain. The treating physician requested a TENS (transcutaneous electrical nerve stimulation) unit. On 08-05-2015, Utilization Review (UR) non-certified the request for a TENS unit.

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: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation BlueCross BlueShield: TENS, CMS: The use of TENS, Aetna and Humana, VA: TENS, European Federation of Neurological Societies (EFNS): TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, the patient has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive physical therapy, activity modifications, yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, whether this is for rental or purchase, nor is there any documented short-term or long-term goals of treatment with the TENS unit. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the treatment already rendered. The TENS unit is not medically necessary and appropriate.