

Case Number:	CM15-0071011		
Date Assigned:	04/21/2015	Date of Injury:	09/17/2014
Decision Date:	06/01/2015	UR Denial Date:	04/01/2015
Priority:	Standard	Application Received:	04/14/2015

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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

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 59 year old male, who sustained an industrial injury on 9/14/2014. He reported hurting his shoulders and his right arm. Diagnoses have included bilateral shoulder strain, brachio-radialis left arm strain, acute left wrist sprain and rotator cuff tear with retraction. Treatment to date has included magnetic resonance arthrogram left shoulder, left rotator cuff repair, physical therapy. According to the progress report dated 3/4/2015, the injured worker was status post left rotator cuff repair. He reported pain and discomfort mostly with motion. Authorization was requested for DME: functional electrical stimulator for home use.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: Functional electrical stimulator for home use: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Bone Growth Stimulator (BGS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tens Page(s): 113.

Decision rationale: According to the MTUS, TENS is not recommended as a primary treatment modality, but a one-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 for the conditions described below: a home based treatment trial of one month may be appropriate for neuropathic pain and CRPS II, CRPS I, neuropathic pain, phantom limb pain, spasticity, multiple sclerosis. According to the documents available for review, injured worker has none of the MTUS/recommended indications for the use of a TENS unit. Therefore, at this time, the requirements for treatment have not been met, and the request is not medically necessary.