

<b>Case Number:</b>	CM13-0015224		
<b>Date Assigned:</b>	03/10/2014	<b>Date of Injury:</b>	01/18/2013
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	08/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/22/2013

### 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 Illinois. 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 patient is a 59-year-old female who reported an injury on 01/18/2013 after a fall. The patient reportedly sustained an injury to her neck, right shoulder, and low back. The patient's treatment history included physical therapy, chiropractic care, and multiple medications. The patient's most recent clinical evaluation documented the patient had tenderness to palpation and spasm of the lumbosacral spine with decreased range of motion, tenderness to palpation and spasm of the thoracolumbar spine with decreased range of motion and tenderness to palpation and spasm of the right shoulder with decreased range of motion. It was documented that the patient had decreased sensation in the bilateral upper extremities and decreased strength in the lower extremities. The patient's diagnoses included a cervical spine disc bulge, cervical spine sprain/strain, left lumbosacral disc bulge, lumbosacral sprain/strain, rotator cuff syndrome, shoulder sprain/strain, and hip sprain/strain. A request was made for an interferential electric muscle stimulator and a home exercise kit for the neck and back.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**INTERFERENTIAL ELECTRIC MUSCLE STIMULATOR:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, Chronic Pain Treatment Guidelines Page(s): 119-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION (ICS) Page(s): 118.

**Decision rationale:** The requested interferential electric muscle stimulator is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends interferential stimulator treatment for patients who have exhausted all other lower levels of chronic pain management treatments. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to a TENS unit. Additionally, California Medical Treatment Utilization Schedule recommends this treatment modality as an adjunct therapy to active therapy. The clinical documentation does not provide any evidence that the patient is currently participating in any active therapy that would benefit from adjunct treatment such as interferential electric muscle stimulator. Also, California Medical Treatment Utilization Schedule recommends patients who meet the criteria for the use of this equipment be provided a 30-day home trial to support the efficacy of this treatment modality. The purchase of this equipment should be based on documentation of functional benefit and symptom response. The clinical documentation submitted for review does not provide any evidence that the patient has undergone a trial of this type of equipment. As such, the requested interferential electric muscle stimulator is not medically necessary or appropriate.

**HOME EXERCISE KIT FOR THE NECK AND BACK:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, EXERCISE

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

**Decision rationale:** The requested home exercise kit for the neck and back are not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend one type of exercise over another. The clinical documentation submitted for review does not provide any evidence that the patient is currently participating in a home exercise program and requires use of additional equipment than what is needed beyond a self-directed home exercise program. Therefore, the need for a home exercise kit for the neck and back are not clearly indicated.