

<b>Case Number:</b>	CM13-0015491		
<b>Date Assigned:</b>	01/10/2014	<b>Date of Injury:</b>	12/07/2011
<b>Decision Date:</b>	03/24/2014	<b>UR Denial Date:</b>	07/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/23/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 physician 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 49-year-old female with date of injury on 12/07/2011. The progress report dated 06/04/2013 by [REDACTED] indicates that the patient's diagnoses include: (1) Right hip strain/adductor strain, (2) Status post nonindustrial motor vehicle accident, (3) MRI showing 7.5-mm disk protrusion encroaching the left existing SI nerve root, (4) 2.2-mm to 3.1-mm disk bulge at multilevel in the cervical spine. The patient continues with pain in the right lower extremity. The patient reports that TENS unit therapy was used during physical therapy visits which provided the patient with good results. The patient would like to have a TENS unit for home use. Exam findings indicate tenderness to palpation of the medial groin in the insertion of the adductor muscles. Hip range of motion causes pain. A request was made for purchase of an OrthoStim4 unit for home use. Utilization review letter dated 07/19/2013 issued non-certification of this request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ortho Stim 4™ (Purchase) and supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) and Galvanic Stimulation Page(s): 121, 117.

**Decision rationale:** The patient continues with right lower extremity pain. The patient had good results with TENS unit therapy during therapy sessions and requested a home unit. Treating physician had requested purchase of an OrthoStim4 unit which includes neuromuscular electrical stimulation as well as galvanic stimulation. MTUS Guidelines page 121 regarding neuromuscular electrical stimulations states that this modality is not recommended. NMES is used primarily as part of a rehabilitation program following a stroke, and there is no evidence to support its use in chronic pain. MTUS page 117 regarding galvanic stimulation states that it is not recommended and is considered an investigational for all indications. The patient appears to have had good results with TENS unit therapy during physical therapy sessions. Therefore, a 30-day trial of home unit therapy would appear to be reasonable. However, the request for the OrthoStim4 unit is not supported by the guidelines noted above. Therefore, recommendation is for denial.