Case Number:	CM13-0061241		
Date Assigned:	12/30/2013	**Date of Injury:**	04/15/2013
Decision Date:	04/07/2014	**UR Denial Date:**	11/25/2013
Priority:	Standard	**Application Received:**	12/04/2013

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 Sports Medicine and is licensed to practice in Texas. 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 47-year-old male who reported an injury on 04/15/2013. The mechanism of injury was cumulative trauma related to the performance of job duties. The patient's complaints include neck, right shoulder, right elbow, forearm, wrist, and hand pain, secondary to repetitive gripping, grasping, and cleaning with forceps. He was initially placed on modified duty in 02/2013 and attended a 6-session course of physical therapy in 04/2013, with some benefit. He later received an MRI of the cervical spine; however, results were not included for review. The patient was then taken off work in 08/2013 for psychological reasons for which he has been treated since 2011, on a private basis. The most recent physical examination dated 11/05/2013 revealed that the patient had spasms to the cervical spine, a positive Spurling's sign and axial compression test, producing pain to the C6 and C7 nerve root distribution, and asymmetric loss of motion. Cervical spine range of motion included 42 degrees of flexion, 50 degrees of extension, 72 degrees of right rotation, and 70 degrees of left rotation. Right lateral flexion was 41 degrees, and left lateral flexion was 37 degrees. Examination of the patient's right shoulder revealed tenderness and muscle spasm to the trapezial and periscapular areas, as well as tenderness to the subacromial and AC joints. There was crepitus present on passive range of motion testing and a slightly positive impingement test. Shoulder range of motion was 170 degrees of flexion, 42 degrees of extension, 155 degrees of abduction, 80 degrees of internal rotation and 85 degrees of external rotation. The right elbow examination revealed tenderness over the lateral epicondyle only, with a flexion of 140 degrees, supination of 80 degrees, and pronation of 80 degrees. The right forearm/wrist/hand examination revealed negative Tinel's and Phalen's tests and range of motion included 60 degrees of flexion, 60 degrees of extension, 20 degrees of radial deviation and 30 degrees of ulnar deviation. Upper extremity reflexes were 2+, there was no weakness to the upper extremity muscles, and a decreased sensation to pinprick and

light touch over the C6 and C7 nerve root distributions in the right arm. At this time, the patient was referred for a course of acupuncture and multiple consultations including psychiatric, dental, internal medicine, and sleep study. There was no other information submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

ORTHOSTIM4 ELECTRICAL MUSCLE STIMULATION UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117, 118, 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Stimulation Page(s): 118, 121.

Decision rationale: The California MTUS/ACOEM Practice Guidelines recommend transcutaneous electrical stimulation to treat pain. There are multiple modalities in an OrthoStim unit, including the modalities of interferential current stimulation and neuromuscular stimulation. The California MTUS/ACOEM Practice Guidelines do not recommend current stimulation as an isolated intervention and should only be used if pain is ineffectively controlled due to the diminished effects or intolerance of medications, if there is a history of substance abuse, or if there is significant pain from a postoperative condition. Furthermore, neuromuscular electrical stimulation is not recommended by guidelines, as it is generally used to prevent or retard disuse atrophy after a cerebrovascular event and is used as part of a comprehensive PT program. As the clinical information submitted for review did not provide evidence that the patient was intolerant to other medications and there was no history of a stroke, major surgery, or disuse atrophy, the medical necessity for this intervention is not established. As such, the request for OrthoStim4 electrical muscle stimulation unit is non-certified.