

<b>Case Number:</b>	CM14-0005306		
<b>Date Assigned:</b>	02/05/2014	<b>Date of Injury:</b>	11/14/2012
<b>Decision Date:</b>	06/12/2014	<b>UR Denial Date:</b>	12/31/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/14/2014

### 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 Orthopedic Surgery 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 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 injured worker is a 65-year-old male who sustained injuries to his left shoulder on 11/14/12 while performing his usual and customary duties as an engineer for a construction company. The physical examination noted left shoulder tenderness with restricted range of motion, decreased strength, and decreased sensation. The injured worker was diagnosed with bilateral shoulder strain/sprain, bilateral shoulder tendonosis, and left shoulder posttraumatic anterior dislocation. Plain radiographs revealed evidence for what appears to be probable inferior dislocation of the short head with no evidence of bony Bankart lesion or deformity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **ELECTRICAL MUSCLE STIMULATION/INTERFERENTIAL (EMS/IF) UNIT REPLACEMENT PURCHASE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-119 AND 121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, CHRONIC PAIN (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION) Page(s): 114-116.

**Decision rationale:** The previous request was denied on the basis that there was no rationale provided for prescription of a dual modality unit, including Electrical Muscle Stimulator (EMS), a modality used for stroke rehabilitation and other conditions, but not recommended for chronic pain. The Chronic Pain Guidelines states that a rental would be preferred over the purchase for a 30-day period. It was not clear that a previous trial had demonstrated functional benefit or that the unit had previously been certified. Given the clinical documentation submitted for review, medical necessity of the request for Electrical Muscle Stimulator/Inteferential (EMS/IF) Unit replacement purchase has not been established. Recommendation is for non-certification.