

<b>Case Number:</b>	CM14-0006586		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	07/11/2011
<b>Decision Date:</b>	06/23/2014	<b>UR Denial Date:</b>	12/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/17/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional 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 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 46 year old with an injury date on 7/11/11. Based on the 12/13/13 progress report provided by [REDACTED] the diagnoses are: chronic pain syndrome, shoulder pain, sprain/strain rotator cuff. Exam of bilateral shoulders on 11/21/13 showed "normal musculature, tenderness anteriorly over biceps tendon. Mild tenderness in lateral subacromial region. On left, supraclavicular tenderness and both shoulders demonstrate tenderness in superior trapezius muscles and mild tenderness in posterior shoulder girdle. Decreased painful range of motion. Impingement sign positive bilateral in Neer and Hawkins position, Yergason's positive on left and negative on right." [REDACTED] is requesting one month trial of neuro stimulator unit for bilateral shoulders. The utilization review determination being challenged is dated 12/13/13. [REDACTED] is the requesting provider, and he provided treatment reports from 1/11/13 to 12/13/13.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **ONE (1) MONTH TRIAL OF NEURO STIMULATOR UNIT FOR BILATERAL SHOULDERS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines, Neuromuscular electrical stimulation Page(s): 12.

**Decision rationale:** This patient presents with constant left shoulder pain that is sharp, snapping, popping rated 10/10, radiating down arm into upper arm, with numbness and tingling in left arm, along with occasional compensatory right shoulder pain. The treater has asked one month trial of neuro stimulator unit for bilateral shoulders on 12/13/13. Regarding neuromuscular electrical stimulation, Chronic Pain Medical Treatment Guidelines, does not recommend due to a lack of clinical evidence supporting its usage to manage chronic pain. The requested one month trial of neuro stimulator unit is not recommended by Chronic Pain Medical Treatment Guidelines, for patient's condition. Given the above the request is not medically necessary.