

<b>Case Number:</b>	CM14-0163490		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	09/27/1997
<b>Decision Date:</b>	11/10/2014	<b>UR Denial Date:</b>	10/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2014

### 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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 female who reported an injury on 09/27/1997. The mechanism of injury was not provided. The injured worker's diagnoses included lumbar herniated nucleus pulposus and right patella fracture. The injured worker's past treatment included a home exercise program and 11 completed physical therapy sessions. Her diagnostic studies included a lumbar spine magnetic resonance imaging on 07/07/2014. Her surgical history included a right knee reconstruction on 10/22/2012. At her exam on 10/07/2014 the injured worker's symptoms included increased lower back pain, limited range of motion, decreased activities of daily living, increased stiffness and past improvement with physical therapy. Upon physical examination the injured worker was noted to have decreased range of motion, positive straight leg raise; (left), positive extensor hallucis longus (left), decreased motor strength, positive extension, flexion and spasm. Documentation submitted for review did not include a medication history. The treatment plan included a consult with another physician. The rationale for the request was not submitted. The request for authorization for authorization form was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prescription for Patches for Knee:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The request for Quad stimulator is not medically necessary. The injured worker had a right knee quad reconstruction on 10/22/2012. As per the note of 08/22/14 the injured worker's right quad remained impaired. There were no significant changes to the right knee since previous visit and she was instructed to continue a home exercise program that included swimming. The Official Disability Guidelines do not recommend neuromuscular electrical stimulation. Neuromuscular electrical stimulation is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. Additionally, there are no intervention trials suggesting benefit from neuromuscular electrical stimulation for chronic pain. (Moore, 1997) (Gaines, 2004) The documentation submitted for review indicated on physical examination of 10/07/2014 the injured worker continued to have pain. Therefore, the request for the Quad Stimulator is not medically necessary.

**Quad Stimulator:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation (NMES).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Chronic Pain, Neuromuscular electrical stimulation

**Decision rationale:** The request for Quad stimulator is not medically necessary. The injured worker had a right knee quad reconstruction on 10/22/2012. As per the note of 08/22/14 the injured worker's right quad remained impaired. There were no significant changes to the right knee since previous visit and she was instructed to continue a home exercise program that included swimming. The Official Disability Guidelines do not recommend neuromuscular electrical stimulation. Neuromuscular electrical stimulation is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. Additionally, there are no intervention trials suggesting benefit from neuromuscular electrical stimulation for chronic pain. (Moore, 1997) (Gaines, 2004) The documentation submitted for review indicated on physical examination of 10/07/2014 the injured worker continued to have pain. Therefore, the request for the Quad Stimulator is not medically necessary.