

Case Number:	CM14-0024778		
Date Assigned:	06/13/2014	Date of Injury:	04/18/2010
Decision Date:	07/15/2014	UR Denial Date:	01/30/2014
Priority:	Standard	Application Received:	02/26/2014

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, 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 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 53 year old with an injury date on 4/8/10. Based on the 1/23/14 progress report provided by [REDACTED] the diagnoses are: 1. Cervico-Brachial Syndrome. 2. Post OP - Left Wrist. 3. CTS Bil Wrist. 4. Probable Post traumatic anxiety 780.52 Probable Post Traumatic Insomnia 724.1 Thoracalgia. 5. Complex Region Pain Syndrome. 6. Shoulder Tenosynovitis Bl Exam on 1/23/14 showed "moderately limited range of motion of C-spine, with hypertonicity in cervical region on both sides. Decreased range of motion of bilateral shoulders. Dural tension signs or brachial plexus tension signs with flexion and abduction of left shoulder." [REDACTED] is requesting electrical muscle stimulation 1x week for 6 weeks. The utilization review determination being challenged is dated 1/30/14. [REDACTED] is the requesting provider, and he provided treatment reports from 8/22/13 to 1/24/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTRICAL MUSCLE STIMULATION 1 X WEEK FOR 6 WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: This patient presents with bilateral shoulder pain, bilateral posterior neck pain, wrist, hand, and back pain. The treater has asked electrical muscle stimulation 1x week for 6 weeks on 1/23/14. The 1/23/14 report shows patient has increasing pain, spasms and restriction of motion in neck and shoulders. Patient has attempted acupuncture, home stretching, ice/heat treatments to some improvement on 12/15/13. There is no indication in records that patient has suffered from stroke or muscle spasms. Regarding neuromuscular electrical stimulation, MTUS recommends as part of rehabilitative treatment program for stroke, but not indicated for chronic pain. In this case, the treater has asked for electrical muscle stimulation which is not recommended by MTUS for patient's condition. Recommendation is for denial.