MAXIMUS Federal Services

| Case Number: | CM15-0191600 | | |
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| Date Assigned: | 10/07/2015 | Date of Injury: | 07/02/2014 |
| Decision Date: | 11/18/2015 | UR Denial Date: | 09/28/2015 |
| Priority: | Standard | Application Received: | 09/29/2015 |

## 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: New York, West Virginia, Pennsylvania
Certification(s)/Specialty: Emergency Medicine

## 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 32 year old female, who sustained an industrial injury on 7-2-14. The injured worker is being treated for chondromalacia patella, cervical (HNP) herniated nucleus pulposus and cervical and lumbar radiculopathy. Treatment to date has included 24 sessions of chiropractic therapy, 8 sessions of physical therapy, Advil, transcutaneous electrical nerve stimulation (TENS) unit (with some pain relief), oral medications including Relafen, Prilosec, Advil and Flexeril; topical Ketoprofen. On 7-31-15 the injured worker complained of pain in right shoulder and pain in right knee with weak quadriceps muscle on right lower extremity. Work status is noted to be modified duty. There were no objective findings noted on 7-31-15. Physical exam performed on 8-14-15 revealed tenderness over the right parascapular region where the trapezius attaches from the midline of the thoracic spine to the scapular border, medial edge and pain is reproduced by backward extension of shoulder and raising the arm. On 7-28-15 a request for EMS stimulator to strengthen right quadriceps was submitted. On 9-28-15 request for EMS stimulator was non-certified by utilization review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Electrical muscle stimulation (EMS) Unit plus supplies, 1-3 month rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

**Decision rationale:** Guidelines do not support electrical stimulation as a primary treatment modality and reserves its use for one month home based trial in patients with an adjunct program of functional restoration who have failed 3 months of conservative therapy. In this case, there is no documented failure of conservative therapy or adjunct program of functional restoration. The request for electrical stimulation unit is not medically appropriate and necessary.