

<b>Case Number:</b>	CM14-0131812		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	04/18/2014
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	07/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2014

### 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 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 injured worker is a 39-year-old female who sustained an injury on 4/18/14. On 6/6/14 she complained of constant, moderate, dull and sharp pain in the right shoulder, cervical, lumbar and thoracic spine. Cervical pain radiated to the right shoulder and arm and lumbar spine pain radiated to the right leg. Exam of the cervical spine showed decreased range of motion with pain, muscle spasm and tenderness to palpation of the cervical paravertebral muscles. Cervical compression was positive. On thoracic spine examination, there was muscle spasm and tenderness to palpation of the thoracic paravertebral muscles. On lumbar spine examination, range of motion was decreased and painful with muscle spasm and tenderness to palpation of the lumbar paravertebral muscles. Kemp's was positive. On right shoulder examination, range of motion was decreased and painful with tenderness to palpation of the acromioclavicular joint, anterior shoulder and posterior shoulder. Right shoulder X-ray dated 5/30/14 was unremarkable; x-ray of the thoracic and lumbar spine revealed thoracic levoconvex scoliosis and myospasms, and lumbar dextroconvex scoliosis and myospasms. Prior treatment included physical therapy, chiropractic therapy and medications. Diagnoses: Cervical radiculopathy, cervical sprain and strain, thoracic musculoligamentous injury, right shoulder internal derangement, and right shoulder myoligamentous injury. The request for electrical muscle stimulation unit and TENS unit was denied on 7/16/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Electrical Muscle Stimulation unit:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter

**Decision rationale:** Per guidelines, neuromuscular electrical stimulation (NMES) devices are not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. Neuromuscular Electrical Stimulation Devices (NMES), NMES, through multiple channels, attempts to stimulate motor nerves and alternately causes contraction and relaxation of muscles, unlike a TENS device which is intended to alter the perception of pain. Also used to stimulate quadriceps muscles following major knee surgeries to maintain and enhance strength during rehabilitation. The records do not support the medical necessity of the requested device per guidelines; thus Electrical Muscle Stimulation unit is not medically necessary and appropriate.

**Transcutaneous electrical Stimulation unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Page(s): 110.

**Decision rationale:** According to the CA MTUS guidelines, TENS is not recommended as a primary therapy for chronic pain, but is recommended as a one-month home-based TENS trial, which may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions such as: Neuropathic pain, Phantom limb pain, Spasticity, and Multiple sclerosis. The medical records do not document a reason for the requested TENS unit. There is no documented neuropathic pain or spasticity to establish the need for the TENS unit. Based on the CA MTUS guidelines and criteria as well as the clinical documentation stated above, the request is not certified as medically necessary.