

<b>Case Number:</b>	CM15-0001913		
<b>Date Assigned:</b>	01/12/2015	<b>Date of Injury:</b>	05/12/2014
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	12/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 62-year-old male with a reported date of injury of 05/12/2014. The injured worker was reportedly injured while changing a computer system. The current diagnoses include right shoulder strain and neck strain. The latest physician progress report submitted for this review is documented on 09/02/2014. The injured worker presented with complaints of right shoulder pain and neck pain. Upon examination, there was tenderness of the right paraspinal muscle, flexion to the chest, extension to 15 degrees, tenderness over the trapezius and right shoulder, right shoulder flexion of 160 degrees with discomfort abduction of 150 degrees and limited grip strength on the right. Recommendations included additional physical therapy and ice therapy. The injured worker was given a prescription for Orudis 75 mg. There was no Request for Authorization form submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prime dual neurostimulator (TENS/EMS unit); one month home trial:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-117.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

**Decision rationale:** California MTUS Guidelines transcutaneous electrotherapy is not recommended as a primary treatment modality but a 1 month home based trial may be considered as a noninvasive conservative option. In this case, there was no evidence of a failure of other appropriate pain modalities including medication. Additionally, the medical necessity for a dual neurostimulator has not been established in this case. Given the above, the request is not medically appropriate.