

Case Number:	CM13-0029995		
Date Assigned:	02/05/2014	Date of Injury:	06/15/2012
Decision Date:	04/23/2014	UR Denial Date:	09/13/2013
Priority:	Standard	Application Received:	09/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician 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 Physician 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:

According to the records made available for review, this is a 54-year-old female with a 6/5/12 date of injury. At the time (8/26/13) of request for authorization for Ortho Stim 4 unit, there is documentation of subjective (left elbow/forearm pain, left shoulder/periscapular pain with radiating pain to the chest, and headaches) and objective (tenderness to palpation over the subacromial region, acromioclavicular joint, supraspinatus tendon and periscapular musculature, positive impingement and cross arm tests on the left, decreased left shoulder range of motion, tenderness to palpation over the left lateral epicondyle, positive Cozen's test, and decreased range of motion of the left elbow) findings, current diagnoses (left shoulder/trapezius strain with impingement syndrome and left elbow/forearm sprain with lateal epicondylitis), and treatment to date (acupuncture).

IMR ISSUES, DECISIONS AND RATIONALES

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

ORTHO STIM 4 UNIT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS), Page(s): 117-120.

Decision rationale: The OrthoStim unit is a combination of neuromuscular stimulation, interferential current stimulation, Galvanic stimulation, and transcutaneous electrotherapy. The MTUS Chronic Pain Medical Treatment Guidelines identify that galvanic stimulation is not recommended and considered investigational for all indications; that neuromuscular stimulation is not recommended and is used primarily as part of a rehabilitation program following stroke with no evidence to support its use in chronic pain. Within the medical information available for review, there is documentation of diagnoses of left shoulder/trapezius strain with impingement syndrome and left elbow/forearm sprain with lateral epicondylitis. However, OrthoStim contains at least one component (Galvanic stimulation) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Ortho Stim 4 unit is not medically necessary.