

<b>Case Number:</b>	CM14-0018200		
<b>Date Assigned:</b>	04/21/2014	<b>Date of Injury:</b>	05/03/2009
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	01/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 Internal and Emergency Medicine and is licensed to practice in Florida. 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:

This patient is a 51 year-old with a date of injury of 05/03/09. A progress report associated with the request for services, dated 01/02/14, identified subjective complaints of bilateral shoulder pain. Objective findings included tenderness to palpation of both shoulders and the right elbow. There was decreased right grip strength. Diagnoses included left shoulder pain; right elbow pain; carpal tunnel syndrome and depression. Treatment has included arthroscopic surgery on the left shoulder, right epicondylar elbow surgery, and left shoulder biceps tenodesis revision. He has received anti-seizure agents and topical analgesics.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **3 MONTH RENTAL OF MEDS3 NEUROMUSCULAR STIMULATOR:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

**Decision rationale:** In this case, the multiple criteria (documentation of duration of pain, trial plan, and goal plan) have not been met. The Guidelines state that a one-month rather than three-month trial should be attempted. Last, the Meds3 Neuromuscular Stimulator uses some

modalities that are not recommended. Therefore, the request for a Meds3 Neuromuscular Stimulator unit is not medically necessary and appropriate.

**CONDUCTIVE GARMENT, PURCHASE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

**Decision rationale:** In this case, the multiple criteria (documentation of duration of pain, trial plan, and goal plan) have not been met. The Guidelines state that a one-month rather than three-month trial should be attempted. Therefore, there is no documented medical necessity for a conductive garment.