

<b>Case Number:</b>	CM14-0126570		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	01/24/2014
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	07/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/11/2014

### 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 Occupational Medicine, 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 female with a date of injury of 1/24/2014. Per the primary treating physician's progress report dated 7/9/2014, the injured worker continues to note benefit in her right shoulder following therapy, as well as the cortisone injection. It is her right wrist that bothers her the most. She describes this as exquisite pain exacerbated with any use of the hand and wrist. She has had two prior cortisone injections for the hand and wrist with only temporary benefit. On examination of the right shoulder, passive forward flexion is to 160 degrees. There is a mildly positive impingement sign. Strength globally is intact. On examination of the right hand and wrist, there is exquisite tenderness over the first dorsal compartment and markedly positive Finkelstein's test. Diagnoses include right de Quervain's stenosis tenosynovitis and right shoulder partial rotator cuff tear, impingement syndrome.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cryotherpay Unit/Surgi Stim Rental For Seven Days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-118, 121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) section Page(s): 118-120. Decision based on Non-

MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter, Continuous-flow cryotherapy section.

**Decision rationale:** The ODG Guidelines recommend the use of continuous-flow cryotherapy as an option after surgery, but not for nonsurgical treatment, and may be used for up to 7 days. This request does not appear to be associated with the requested surgical release of the dorsal compartment of the right hand/wrist, but as continued passive therapy that was provided during therapist guided physical therapy sessions. The MTUS Guidelines do not recommend an interferential stimulator as an isolated treatment; however, it may be useful for a subset of individuals that have not had success with pain medications. The evidence that an interferential stimulator is effective is not well supported in the literature, and studies that show benefit from use of the interferential stimulator are not well designed to clearly demonstrate cause and effect. The guidelines support the use of an interferential stimulator for a one month trial to determine if this treatment modality leads to increased functional improvement, less reported pain and medication reduction. The electrical stimulation provided in therapy is also not accompanied with a report of efficacy of the treatment. As such, the request is not medically necessary.