

<b>Case Number:</b>	CM14-0137361		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	03/02/2012
<b>Decision Date:</b>	10/02/2014	<b>UR Denial Date:</b>	08/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2014

### 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 and 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:

According to the records made available for review, this is a 40-year-old female with a 3/2/12 date of injury. At the time (8/1/14) of request for authorization for Home OrthoStim 4 Unit, there is documentation of subjective (right shoulder pain and limited range of motion) and objective (right shoulder tenderness, positive impingement, cervical spine tenderness) findings, current diagnoses (right wrist flexor/extensor tendinitis, carpal tunnel syndrome, right elbow lateral and medial epicondylitis, right shoulder impingement, left elbow lateral and medial epicondylitis), and treatment to date (medications physical therapy, and home exercise program).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home OrthoStim 4 Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS), Neuromuscular electrical.

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

**Decision rationale:** OrthoStim unit is a combination of neuromuscular stimulation, interferential current stimulation, Galvanic stimulation, and transcutaneous electrotherapy. 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 right wrist flexor/extensor tendinitis, carpal tunnel syndrome, right elbow lateral and medial epicondylitis, right shoulder impingement, left elbow lateral and medial 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 Home OrthoStim 4 unit is not medically necessary.