

<b>Case Number:</b>	CM14-0028471		
<b>Date Assigned:</b>	06/18/2014	<b>Date of Injury:</b>	10/23/2013
<b>Decision Date:</b>	07/23/2014	<b>UR Denial Date:</b>	02/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2014

### 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 patient is a 42 year-old female with date of injury 10/23/2013. The medical record associated with the request for authorization, a primary treating physician's initial medical report, dated 02/06/2014, lists subjective complaints as pain to both shoulders, right side greater than left and pain in the upper extremities, right side greater than left. Objective findings: Examination of the right wrist revealed tenderness of the bilateral volar carpal ligament and decreased range of motion with pain. Tinel's and Pahlen's test were positive. Examination of the right shoulder revealed tenderness on the acromioclavicular joint, right acromion, right greater tuberosity, bilateral bicipital groove, right subacromial bursa, bilateral superior angle of the scapula, right spine of the scapula, right inferior angle of the scapula and bilateral upper trapezius muscles. Impingement's test was equivocal on the right. Diagnoses include: 1. Bilateral shoulder strain/sprain with right side greater than left, rule out internal derangement 2. Cervical strain/sprain with radiculitis, rule out disc herniation 3. Bilateral medial epicondylitis with right side greater than left, rule out internal derangement 4. Bilateral wrist strain/sprain with right side greater than left, rule out internal derangement 5. Left hip strain/sprain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME: PRO TECH MULTI STIM UNIT FOR THE RIGHT SHOULDER AND RIGHT WRIST:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

**Decision rationale:** The pro tech multi stim unit is a multiple stimulation unit that provides tendons, and differential, and neuromuscular stimulation currents. Multiple stimulation units are not recommended by the MTUS Chronic Pain Guidelines. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue, shoulder pain, cervical neck pain and knee pain. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. As such, the request is not medically necessary and appropriate.