

<b>Case Number:</b>	CM14-0031341		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	02/17/2012
<b>Decision Date:</b>	07/17/2014	<b>UR Denial Date:</b>	02/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2014

### 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 Anesthesiology, has a subspecialty in Pain Management, 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 51-year-old male with a February 17, 2012 date of injury, status post left elbow/forearm ulnar nerve decompression and transposition 9/13. At the time of request for authorization for OrthoStim/Interferential Unit rental with supplies- times two months and Thermophore heating pad (February 25, 2014), there is documentation of subjective (residual symptoms with on/off flare-ups increased with lifting, pushing, and pulling-type activities; left elbow/forearm pain with intermittent numbness and tingling to the 4th and 5th digits of the left hand) and objective (slight swelling along the medial epicondyle and cubital tunnel region, tenderness to palpation over the medial epicondyle extending over the proximal forearm flexor muscles, subluxation of the ulnar nerve at the ulnar groove with passive and active flexion, positive Cozen's, and Tinel's sign) findings, current diagnoses (status post left elbow/forearm ulnar nerve decompression and transposition 9/13, with medial epicondylitis and residual cubital tunnel syndrome), and treatment to date (physical therapy, medications, and home exercise program). A February 3, 2014 medical report identifies a request for OrthoStim IV/Interferential unit and Thermophore heating pad to help the patient manage his current symptomatology and facilitate/enhance his home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Two month rental of Orthostim/Interferential Unit with supplies:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that the OrthoStim unit is a combination of neuromuscular stimulation, interferential current stimulation, Galvanic stimulation, and transcutaneous electrotherapy. The 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 status post left elbow/forearm ulnar nerve decompression and transposition 9/13, with medial epicondylitis and residual cubital tunnel syndrome. However, OrthoStim contains at least one component (Galvanic stimulation) that is not recommended. The request for two month rental of Orthostim/Interferential Unit with supplies is not medically necessary or appropriate.

**Thermophore heating pad:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 235. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG Elbow Chapter, Heat packs.

**Decision rationale:** The Elbow Disorders Chapter of the ACOEM Practice Guidelines states that patient's at home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by therapists. The ODG identifies recommends at-home applications of cold packs during first few days; thereafter applications of either heat or cold packs to suit patient. Within the medical information available for review, there is documentation of diagnoses of status post left elbow/forearm ulnar nerve decompression and transposition 9/13, with medial epicondylitis and residual cubital tunnel syndrome. In addition, there is documentation of a request for Thermophore heating pad to help the patient manage his current symptomatology and facilitate/enhance his home exercise program. The request for a Thermophore heating pad is medically necessary and appropriate.