

<b>Case Number:</b>	CM14-0117012		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	05/15/2012
<b>Decision Date:</b>	10/07/2014	<b>UR Denial Date:</b>	07/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2014

### 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 & Rehabilitation, and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 42-year-old female was reportedly injured on May 15, 2012. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated August 19, 2014, indicated that there were ongoing complaints of cervical spine pain, right elbow pain, right shoulder pain, and right wrist pain. The physical examination demonstrated tenderness along the cervical spine paravertebral muscles and decreased range of motion. Examination of the right shoulder noted tenderness of the rotator cuff region and decreased range of motion. There was a negative impingement test. There was also tenderness at the right elbow with decreased elbow range of motion and a positive Cozen's test as well as decreased right wrist motion and a negative Tinel's test. Diagnostic imaging studies were not reviewed during this visit. Previous treatment included oral medications. A request had been made for use of an inferential stimulator with three months of supplies, a cold therapy system purchase, and a SurgiStim unit with supplies and was not certified in the pre-authorization process on July 16, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Inferential Stimulator with supplies rental to purchase with 3 months supplies (electrodes, batteries & wipes): 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 California MTUS Guidelines do not support inferential therapy as an isolated intervention. The guidelines will support a one-month trial in conjunction with physical therapy, an exercise program, and a return to work plan if chronic pain is ineffectively controlled with pain medications or side effects to those medications. Review of the available medical records fails to document any of the criteria required for an IF unit one-month trial. Additionally, this request is for three months of usage. As such, this request for an inferential stimulator with three months of supplies is not medically necessary.

**Surgistim 4 purchase with supplies:** 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:** A SurgiStim unit is an inferential stimulator with also use as a neuromuscular stimulator. The California MTUS Guidelines do not support Interferential therapy as an isolated intervention. The Guidelines will support a one-month trial in conjunction with physical therapy, an exercise program, and a return to work plan if chronic pain is ineffectively controlled with pain medications or side effects to those medications. Review of the available medical records fails to document any of the criteria required for an IF unit one-month trial. Additionally, this request is for purchase rather than a one-month rental for a trial. As such, this request for a SurgiStim unit for purchase with supplies is not medically necessary.

**Cold Therapy System purchase:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous Flow Cryotherapy, Updated August 27, 2014

**Decision rationale:** According to the Official Disability Guidelines, a continuous flow cryotherapy unit is recommended as an option after surgery to help decrease pain, inflammation, swelling, and narcotic usage. However, it is not recommended for nonsurgical treatment. Considering this, the request for a cold therapy system purchase is not medically necessary.