

<b>Case Number:</b>	CM14-0163044		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	03/25/2014
<b>Decision Date:</b>	11/14/2014	<b>UR Denial Date:</b>	09/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2014

### 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 Orthopedic Surgeon and is licensed to practice in Texas. 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 48-year old male who reported an injury on 03/25/2012 from forcefully extending his right arm while conducting in-service baton training. He is diagnosed with right lateral epicondylitis and elbow sprain. His past treatments have included physical therapy, acupuncture treatment, splinting, hot and cold compresses, work activity restrictions, and cortisone injections. Unofficial x-rays of the right arm showed no abnormalities of the bony structures. Past surgical history and medication treatments were not provided. During a clinic visit on 08/26/2014, he reported elbow tenderness as well as pain that increased with range of motion, grasping, pushing, and pulling. His functional deficits were documented on 08/26/2014 and 07/22/2014. Physical findings of the right arm noted a flexion decrease from 140 degrees to 125 degrees, extension remained unchanged at 0 degrees, a positive Radial Tunnel Sign, and inability to lift more than 42 pounds. The treatment plan was to obtain an MRI of the right elbow and included a prescription for Tramadol 50mg every 6-8 hours as needed for pain. Requests were received for the postoperative rental of an x-force stimulator, continuous passive motion, and a cold therapy unit (30 days).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME Rental Post-Op [REDACTED] Stim (Days): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116-117.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-118.

**Decision rationale:** The request for DME Rental Post-Op [REDACTED] Stim (Days) is not medically necessary. During a clinical visit on 08/26/2014, the injured worker was diagnosed with right lateral epicondylitis. The California MTUS Guidelines recommends transcutaneous electrotherapy as a treatment option for acute post-operative pain in the first 30 days of post-surgery, however, it is most effective for the treatment of thoracotomy pain. Evidence-based studies has also shown this device to be less effective or not at all for treatment of other orthopedic surgical procedures. There is no indication of a proposed surgical procedure in the medical record submitted and the request does not indicate the number of rental days for the unit. Based on the documentation submitted, the guidelines do not support this request. As such, the request is not medically necessary.

**DME Rental Post-Op CPM (Days): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, CPM

**Decision rationale:** The request for DME Rental Post-Op CPM (Days) is not medically necessary. During a clinical visit on 08/26/2014, the treatment plan noted obtaining an MRI of the right elbow. The Official Disability Guidelines recommends the use of a CPM for the treatment of capsulitis for up to 4 weeks/5 days a week. An official or unofficial MRI was not provided and there is no diagnosis of capsulitis documented in the medical record submitted. As such, the request is not medically necessary.

**DME Rental Cold Therapy Unit (Days) Qty:30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Continuous-flow cryotherapy

**Decision rationale:** The request for DME Rental Cold Therapy Unit (Days) Qty:30 is not medically necessary. During a clinical visit on 08/26/2014, the injured worker was diagnosed with right lateral epicondylitis. The treatment plan noted obtaining an MRI and a prescription for Tramadol. The Official Disability Guidelines recommends the use of a cold therapy unit as an

option after surgery, but not for nonsurgical treatment. More specifically, it may be used for post-operative treatment up to 7 days, including home use. However, there is no indication of a proposed surgical procedure documented in the medical record submitted. In the absence of this documentation, the request is not medically necessary.