MAXIMUS Federal Services

Case Number:	CM15-0011563		
Date Assigned:	03/09/2015	Date of Injury:	07/08/2014
Decision Date:	04/14/2015	UR Denial Date:	01/06/2015
Priority:	Standard	Application Received:	01/20/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Internal Medicine

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 31 year old male, who sustained an industrial injury on 07/08/2014. He has reported pain in the left hand and right hand. The diagnoses have included mild carpal tunnel syndrome bilaterally; medial and lateral epicondylitis bilaterally; and bilateral shoulder impingement, rotator cuff strain, and bicipital tendinitis bilaterally. Treatment to date has included medications, bracing, physical therapy, and home exercise program. Medications have included Naproxen and Tramadol. A progress note from the treating physician, dated 11/12/2014, documented a follow-up visit with the injured worker. The injured worker reported left hand and right hand pain, as well as pain along the ulnar distribution; and numbness, tingling, and weakness in the hands. Objective findings included tenderness along ulnar nerve bilaterally as well as mild tenderness along carpal tunnel bilaterally. Request is being made for MRI of the bilateral wrists; cortisone injection in the bilateral wrists; thumb spica splints for the bilateral wrists; IF unit purchase with conductive garment; and prescription medications. On 01/06/2015 Utilization Review noncertified a prescription for Naproxen 550 mg #60; Tramadol ER 150 mg #30; Flexeril 7.5 mg #60; Trazodone 50 mg #60; LidoPro 4 oz.; Terocin patches #20; MRI of the bilateral wrists; Cortisone injection in the bilateral wrists; Thumb spica splints for the bilateral wrists; and IF unit purchase with conductive garment. The CA MTUS, ACOEM and the ODG were cited. On 01/20/2015, the injured worker submitted an application for IMR for review of a prescription for Naproxen 550 mg #60; Tramadol ER 150 mg #30; Flexeril 7.5 mg #60; Trazodone 50 mg #60; LidoPro 4 oz.; Terocin patches #20; MRI of the bilateral wrists; Cortisone

injection in the bilateral wrists; Thumb spica splints for the bilateral wrists; and IF unit purchase with conductive garment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page 67-73.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines addresses NSAIDs (non-steroidal anti-inflammatory drugs). All NSAIDS have the U.S. Boxed Warning for associated risk of adverse cardiovascular events, including, myocardial infarction, stroke, and new onset or worsening of pre-existing hypertension. NSAIDs can cause ulcers and bleeding in the stomach and intestines at any time during treatment. Use of NSAIDs may compromise renal function. FDA package inserts for NSAIDs recommend periodic lab monitoring of a CBC complete blood count and chemistry profile including liver and renal function tests. Routine blood pressure monitoring is recommended. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. All NSAIDs have the potential to raise blood pressure in susceptible patients. Medical records document the long-term use of NSAIDS. Per MTUS, it is generally recommended that the lowest dose be used for NSAIDs for the shortest duration of time. The orthopedic progress report dated 12/12/14 documented an elevated blood pressure 156/90. Per MTUS, NSAIDS are associated with the risk of adverse cardiovascular events, including, myocardial infarction, stroke, and new onset or worsening of pre-existing hypertension. Medical records do not present recent laboratory test results, which are recommended for NSAID use per MTUS. Long-term NSAID use is not recommended by MTUS. The use of the NSAID Naproxen is not supported by MTUS guidelines. Therefore, the request for Naproxen is not medically necessary.

Tramadol ER 150mg #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Pages 93-94, 113, 123.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address Ultram (Tramadol). Tramadol (Ultram) is indicated for the management of moderate to moderately severe pain. The orthopedic surgeon's progress report dated 12/12/14 documented the diagnoses of carpal tunnel syndrome, wrist joint inflammation, medial and lateral epidcondylitis bilaterally, and bilateral shoulder impingement, rotator cuff

strain, and bicipital tendinitis bilaterally. Electrodiagnostic studies demonstrated carpal tunnel syndrome. There were objective findings on physical examination. The patient reported severe pain. Per MTUS, Tramadol (Ultram) is indicated for the management of moderate to moderately severe pain. MTUS guidelines support the prescription of Tramadol (Ultram). Therefore, the request for Tramadol is medically necessary.

Flexeril 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-49,Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Pages 41-42. Muscle relaxants Pages 63-66. Decision based on Non-MTUS Citation FDA Prescribing Information Flexeril http://www.drugs.com/pro/flexeril.html.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses muscle relaxants. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) states that muscle relaxants seem no more effective than NSAIDs for treating patients with musculoskeletal problems, and using them in combination with NSAIDs has no demonstrated benefit. Muscle relaxants may hinder return to function by reducing the patient's motivation or ability to increase activity. Table 3-1 states that muscle relaxants are not recommended. Chronic Pain Medical Treatment Guidelines addresses muscle relaxants. Muscle relaxants should be used with caution as a second-line option for short-term treatment. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. According to a review in American Family Physician, muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Chronic Pain Medical Treatment Guidelines state that Cyclobenzaprine (Flexeril) is an option for a short course of therapy. Treatment should be brief. The addition of Cyclobenzaprine to other agents is not recommended. FDA guidelines state that Cyclobenzaprine is indicated for acute musculoskeletal conditions. Cyclobenzaprine should be used only for short periods (up to two or three weeks) because adequate evidence of effectiveness for more prolonged use is not available. The orthopedic progress report dated 12/12/14 did not document muscle spasm or muscle abnormalities on physical examination. Medical records document that the patient's occupational injuries are not acute. MTUS, ACOEM, and FDA guidelines do not support the use of Cyclobenzaprine (Flexeril) for chronic conditions. Long-term use of the muscle relaxant Flexeril is not supported by MTUS and FDA guidelines. The patient has been prescribed NSAIDs. Per MTUS, using muscle relaxants in combination with NSAIDs has no demonstrated benefit. The use of Flexeril is not supported by MTUS or ACOEM guidelines. Therefore, the request for Flexeril (Cyclobenzaprine) is not medically necessary.

Trazodone 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress - Trazodone (Desyrel). ODG - Pain (Chronic) Insomnia treatment.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) does not address Trazodone. Official Disability Guidelines (ODG) state that Trazodone (Desyrel) is recommended as an option for insomnia only for patients with potentially coexisting psychiatric symptoms such as depression or anxiety. There is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression. Evidence for the off-label use of Trazodone for treatment of insomnia is weak. The current recommendation is to utilize a combined pharmacologic and psychological and behavior treatment when primary insomnia is diagnosed. There has been no dose-finding study performed to assess the dose of Trazodone for insomnia in non-depressed patients. Other pharmacologic therapies should be recommended for primary insomnia before considering Trazodone, especially if the insomnia is not accompanied by comorbid depression or recurrent treatment failure. There is no clear-cut evidence to recommend Trazodone first line to treat primary insomnia. The recommendation is to discontinue the medication after a few weeks. The request for Trazodone 50 mg #60 is not supported by ODG guidelines. Therefore, the request for Trazodone 50 mg #60 is not medically necessary.

LidoPro 4oz: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page 111-113. NSAIDs (non-steroidal anti-inflammatory drugs) Page 67-73. Capsaicin, topical Page 28-29.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The efficacy in clinical trials of topical NSAIDs has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be either not superior to placebo after two weeks, or with a diminishing effect after two weeks. For osteoarthritis of the knee, topical NSAID effect appeared to diminish over time. There are no long-term studies of their effectiveness or safety for chronic musculoskeletal pain. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Topical NSAIDs are not recommended for neuropathic pain as there is no evidence to support use. MTUS Chronic Pain Medical Treatment Guidelines addresses NSAIDs (non-steroidal anti-inflammatory drugs). All NSAIDS have the U.S. Boxed Warning for associated risk of adverse cardiovascular events, including, myocardial infarction, stroke, and new onset or worsening of pre-existing hypertension. NSAIDs can cause ulcers and bleeding in the stomach and intestines at any time during treatment. Use of NSAIDs may compromise renal function. FDA package inserts for

NSAIDs recommend periodic lab monitoring of a CBC complete blood count and chemistry profile including liver and renal function tests. Routine blood pressure monitoring is recommended. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. Besides Lidoderm, no other commercially approved topical formulation of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend topical Lidocaine for chronic neuropathic pain disorders other than post-herpetic neuralgia. Topical Lidocaine is not recommended for non-neuropathic pain. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. Capsaicin is only an option in patients who have not responded or are intolerant to other treatments. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. LidoPro contains capsaicin, lidocaine, menthol, and methyl salicylate. Medical records document the long-term use of NSAIDS. Per MTUS, it is generally recommended that the lowest dose be used for NSAIDs for the shortest duration of time. The orthopedic progress report dated 12/12/14 documented an elevated blood pressure 156/90. Per MTUS, NSAIDS are associated with the risk of adverse cardiovascular events, including, myocardial infarction, stroke, and new onset or worsening of pre-existing hypertension. Medical records do not present recent laboratory test results, which are recommended for NSAID use per MTUS. Long-term NSAID use is not recommended by MTUS. The use of a topical NSAID is not supported by MTUS guidelines. Medical records indicate long-term NSAID use, which is not recommended by MTUS. Methyl salicylate, a component of LidoPro, is a NSAID. There is no documentation that the patient has not responded or is intolerant to other treatments. This is a requirement for the use of topical Capsaicin per MTUS. There was no documentation of post-herpetic neuralgia. Per MTUS, further research is needed to recommend topical Lidocaine for chronic neuropathic pain disorders other than post-herpetic neuralgia. Topical Lidocaine is not recommended for non-neuropathic pain. MTUS guidelines and medical records do not support the medical necessity of a topical analgesic containing Methyl S alicylate, Capsaicin, and Lidocaine, which are ingredients in LidoPro. Per MTUS guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore, the request for LidoPro is not medically necessary.

Terocin patches #20: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page 111-113. NSAIDs (non-steroidal anti-inflammatory drugs) Page 67-73. Capsaicin, topical Page 28-29. Decision based on Non-MTUS Citation Terocin http://www.drugs.com/pro/terocin.html.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Besides Lidoderm,

no other commercially approved topical formulation of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend topical Lidocaine for chronic neuropathic pain disorders other than post-herpetic neuralgia. Topical Lidocaine is not recommended for non-neuropathic pain. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. The efficacy in clinical trials of topical NSAIDs has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be either not superior to placebo after two weeks or with a diminishing effect after two weeks. For osteoarthritis of the knee, topical NSAID effect appeared to diminish over time. There are no long-term studies of their effectiveness or safety for chronic musculoskeletal pain. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Topical NSAIDs are not recommended for neuropathic pain as there is no evidence to support use. MTUS Chronic Pain Medical Treatment Guidelines addresses NSAIDs (non-steroidal anti-inflammatory drugs). All NSAIDS have the U.S. Boxed Warning for associated risk of adverse cardiovascular events, including, myocardial infarction, stroke, and new onset or worsening of pre-existing hypertension. NSAIDs can cause ulcers and bleeding in the stomach and intestines at any time during treatment. Use of NSAIDs may compromise renal function. FDA package inserts for NSAIDs recommend periodic lab monitoring of a CBC complete blood count and chemistry profile including liver and renal function tests. Routine blood pressure monitoring is recommended. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. Capsaicin is only an option in patients who have not responded or are intolerant to other treatments. Terocin is a topical analgesic, containing methyl salicylate, capsaicin, menthol and lidocaine hydrochloride. Medical records document the long-term use of NSAIDS. Per MTUS, it is generally recommended that the lowest dose be used for NSAIDs for the shortest duration of time. The orthopedic progress report dated 12/12/14 documented an elevated blood pressure 156/90. Per MTUS, NSAIDS are associated with the risk of adverse cardiovascular events, including, myocardial infarction, stroke, and new onset or worsening of pre-existing hypertension. Medical records do not present recent laboratory test results, which are recommended for NSAID use per MTUS. Long-term NSAID use is not recommended by MTUS. The use of a topical NSAID is not supported by MTUS guidelines. Medical records indicate long-term NSAID use, which is not recommended by MTUS. Medical records do not document a diagnosis of post-herpetic neuralgia, which is the only FDA approved indication for topical Lidocaine. The use of topical Lidocaine is not supported. There is no documentation that the patient has not responded or is intolerant to other treatments. Per MTUS, this is a requirement for the use of topical Capsaicin. Per MTUS guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore, the request for Terocin is not supported by MTUS guidelines. Therefore, the request for Terocin is not medically necessary.

MRI of the bilateral wrists: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome (Acute & Chronic) MRI (magnetic resonance imaging).

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses MRI magnetic resonance imaging. Medical Treatment Utilization Schedule (MTUS) American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints indicates that MRI magnetic resonance imaging has a relatively low ability to identify and define carpal tunnel syndrome CTS pathology. Official Disability Guidelines (ODG) Carpal Tunnel Syndrome (Acute & Chronic) indicates that MRI magnetic resonance imaging is not recommended in the absence of ambiguous electrodiagnostic studies. Electrodiagnostic studies are likely to remain the pivotal diagnostic examination in patients with suspected CTS for the foreseeable future, but MR imaging may contribute to the diagnosis of CTS for patients with ambiguous electrodiagnostic studies and clinical examinations. The progress report dated 9/18/14 documented that electrodiagnostic studies demonstrated left carpal tunnel syndrome. The electrodiagnostic studies were not noted to be ambiguous. ODG and ACOEM guidelines do not support the request for MRI of bilateral wrists. Therefore, the request for MRI of bilateral wrists is not medically necessary.

Cortisone injection in the bilateral wrists: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265 and 269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, 272.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses carpal tunnel syndrome. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints indicates that injection of corticosteroids into carpal tunnel in mild or moderate cases of CTS carpal tunnel syndrome after trial of splinting and medication. Most invasive techniques, such as needle acupuncture and injection procedures, have insufficient high quality evidence to support their use. The exception is corticosteroid injection about the tendon sheaths or, possibly, the carpal tunnel in cases resistant to conservative therapy for eight to twelve weeks. For optimal care, a clinician may always try conservative methods before considering an injection. CTS may be treated for a similar period with a splint and medications before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits). Symptomatic relief from a cortisone / anesthetic injection will facilitate the diagnosis; however, the benefit from these injections is short-lived. The orthopedic report dated 12/12/14 documented a diagnosis of mild carpal tunnel syndrome. The request for cortisone injections to both wrists was made on 12/12/14. Wrist splints were prescribed December 12, 2014. Physical therapy began on January 6, 2015. Per ACOEM, injection of corticosteroids into carpal tunnel in mild or moderate cases of CTS carpal tunnel syndrome after trial of splinting and medication.

Because a trial of splinting, oral medications, and physical therapy has not been completed, the request for cortisone injections is not supported by MTUS & ACOEM guidelines. Therefore, the request for cortisone injections of both wrists is not medically necessary.

Thumb spica splints for the bilateral wrists: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264, 265, 272.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses splinting for carpal tunnel syndrome (CTS). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints states that when treating with a splint in CTS, scientific evidence supports the efficacy of neutral wrist splints. Splinting should be used at night, and may be used during the day, depending upon activity. Initial treatment of CTS should include night splints. Day splints can be considered for patient comfort as needed to reduce pain, along with work modifications. For carpal tunnel syndrome, splinting of wrist in neutral position at night & day. Table 11-7 Summary of Recommendations for Evaluating and Managing Forearm, Wrist, and Hand Complaints indicates that splinting as conservative treatment for CTS carpal tunnel syndrome and strains is recommended. The orthopedic surgeon's progress report dated 12/12/14 documented the diagnoses of carpal tunnel syndrome, wrist joint inflammation, medial and lateral epicondylitis bilaterally, and bilateral shoulder impingement, rotator cuff strain, and bicipital tendinitis bilaterally. The request for bilateral wrist splints is supported by MTUS & ACOEM guidelines. Therefore, the request for thumb spica splints for bilateral wrists is medically necessary.

IF unit purchase with conductive garment: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271,Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page 114-121. Interferential Current Stimulation (ICS) Pages 118-120. Electrical stimulators (E-stim) Page 45. Decision based on Non-MTUS Citation Work Loss Data Institute - Pain (chronic) http://www.guideline.gov/content.aspx?id=47590 Work Loss Data Institute - Forearm, wrist, & hand (acute & chronic) http://www.guideline.gov/content.aspx?id=47580.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines addresses interferential current stimulation (ICS). Interferential current stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments. 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 post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and methodologic issues. Although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints Table 11-7 Summary of Recommendations for Evaluating and Managing Forearm, Wrist, and Hand Complaints (Page 271) indicates that regarding physical treatment methods, TENS units and passive modalities are not recommended. Work Loss Data Institute guidelines for the forearm, wrist, & hand (acute & chronic) indicates that electrical stimulators (E-stim) are not recommended. Work Loss Data Institute guidelines for chronic pain (2013) indicates that interferential current stimulation (ICS) are not recommended. The orthopedic surgeon's progress report dated 12/12/14 documented the diagnoses of carpal tunnel syndrome, wrist joint inflammation, medial and lateral epidcondylitis bilaterally, and bilateral shoulder impingement, rotator cuff strain, and bicipital tendinitis bilaterally. MTUS, ODG, and Work Loss Data Institute guidelines do not support the use of interferential therapy. Therefore, the request for IF interferential unit is not medically necessary.