

<b>Case Number:</b>	CM13-0020575		
<b>Date Assigned:</b>	04/25/2014	<b>Date of Injury:</b>	12/23/2008
<b>Decision Date:</b>	07/04/2014	<b>UR Denial Date:</b>	07/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/05/2013

### 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 and Rehabilitation 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:

This 42 year-old female sustained an injury on 12/23/03 while employed by [REDACTED]. Requests under consideration include TENS UNIT and LEFT WRIST BRACE. MRI of the Left wrist on 3/29/13 showed normal flexor/extensor tendons; normal ligaments with intact triangular fibrocartilage complex; normal median nerve and Guyon's canal; no marrow edema of distal radius and ulnar; subcondral cyst at proximal lunate; normal CMC, intercarpal and distal radioulnar joints with scapholunate distance normal with capitolunate angle increased suggestive of DISI. Report of 5/29/13 from the provider noted patient is s/p left shoulder open decompression (undated); and lumbar fusion with instrumentation at L5-S1 in April 2010. The continues to treat for chronic pain of the neck, shoulder (left), and left wrist. Exam noted cervical and lumbar spine musculature spasms with restricted range; decreased sensation on left C6 distribution; TTP over cervicotracheal ridge; left shoulder with painful range; ff and abduction to 80 degrees; tenderness over AC joint; left wrist and hand has positive tenderness over ulnar aspect; lumbar spine showed limited painful range of motion; spasm; positive Lasegue and SLR at 65 degrees on left with motor strength of 4/5. Diagnoses include s/p lumbar fusion/discogenic disease; chronic cervical sprain/strain with HNP at C5-6; s/p left shoulder open decompression with impingement and rotator cuff partial thickness tear; and possible DISI pattern instability. Requests above were non-certified on 7/15/13 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS UNIT:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY Page(s): 115-118.

**Decision rationale:** Per Chronic Pain Medical Treatment Guidelines, criteria for TENS use include documented chronic intractable pain with evidence that other appropriate pain modalities have been tried and failed, including medication. A one-month trial rental period of the TENS unit is preferred with use as an adjunct to ongoing treatment modalities within a functional restoration approach. Criteria also includes notation on how often the unit was to be used, as well as outcomes in terms of pain relief and function of other ongoing pain treatment during this trial period including medication usage. A treatment plan should include the specific short- and long-term goals of treatment with the TENS unit. Submitted reports have not adequately demonstrated indication and necessity to support for this DME purchase/rental. The TENS UNIT is not medically necessary and appropriate.

**LEFT WRIST BRACE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm-Wrist-Hand, Splints, page(s): 177-178.

**Decision rationale:** MRI of the Left wrist on 3/29/13 showed normal flexor/extensor tendons; normal ligaments with intact triangular fibrocartilage complex; normal median nerve and Guyon's canal; no marrow edema of distal radius and ulnar; subcondral cyst at proximal lunate; normal CMC, intercarpal and distal radioulnar joints with normal scapholunate distance; capitulunate angle increased possibly suggestive of DISI. In all cases, braces need to be used in conjunction with a rehabilitation program and are necessary only if the patient is required to maintain certain immobilization or assist in functional activity. However, there are no documented reports regarding specific neurological deficits of the wrist or specific clinical findings of possible instability requiring immobilization. MRI showed possible pattern of DISI; however, clinical exam only noted tenderness without other clinical findings for any wrist issues that would support the wrist brace. ACOEM Guidelines support splinting as first-line conservative treatment for CTS, DeQuervain's, Strains; however, none have been demonstrated to support for this wrist brace. Therefore the Left Wrist Brace purchase is not medically necessary and appropriate.