

<b>Case Number:</b>	CM13-0032187		
<b>Date Assigned:</b>	12/04/2013	<b>Date of Injury:</b>	04/09/2013
<b>Decision Date:</b>	02/06/2014	<b>UR Denial Date:</b>	09/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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 patient is a 42 year old male who reported injury on 04/09/2013. The mechanism of injury was noted to be the patient was helping another department and the patient slipped and fell backwards. It was further noted, as the patient was falling, he/she used their hand to brace themselves and landed on her/his back and his/her wrists. The patient was noted to have surgery, an excision of the triangular fibrocartilage, chondroplasty of the scaphoid, partial synovectomy, removal of loose bodies, and a debridement of the scapholunate ligament, as well as a carpal tunnel release of the right wrist and a flexor tenosynovectomy of the right wrist. The patient was noted to be treated with 12 sessions of physical therapy and 6 sessions of acupuncture. The surgery was performed post the date of the request. The diagnoses were noted to include moderate right wrist and elbow carpal tunnel and cubital tunnel syndrome, right wrist scapholunate ligament tear, and partial radial-ulnar ligament tear. Request was made for a Micro-Z glove, a cold unit for 30 days, and post-operative physical therapy 2x4 to the right wrist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Micor 7 glove for right hand/wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.neuropathyjointpain.com/products.html>.

**Decision rationale:** Per the neuropathyjointpain.com products web site, "The Micro-Z and The Micro-Z MINI is a small, lightweight stimulator that allows patients to receive electrotherapeutic treatment in comfort. It is programmed for 2 treatment protocols, the first is a 30-minute daytime treatment and the second is an 8-hour nighttime treatment that is administered while the patient sleeps." While California MTUS Guidelines do not address the Micro-Z glove, they do address the micro current electrical stimulation, the MENS device, which is not recommended. There is a lack of documented evidence for the use of the device. Additionally, another type of device, a neuromuscular electrical stimulation (NMES) device, is used primarily as a part of a rehabilitation program following stroke, and there is no evidence to support its use in chronic pain. The clinical documentation submitted for review fails to provide the type of current the glove provides. Additionally, it failed to provide a documented rationale for the use of the glove. The clinical documentation submitted for review indicated the request was for a Micro-Z glove; however, per the submitted request, the request is for a micor 7 glove for the right hand. Given the above, the lack of clarification and the lack of documentation, the request for micor 7 glove for right hand/wrist is not medically necessary.

**Post-operative cold unit for 30 days in regards to the right wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Chapter, Continuous Cold Therapy.

**Decision rationale:** Official Disability Guidelines recommend continuous cold therapy in the postoperative setting with a limitation of 7 days. The clinical documentation submitted for review failed to provide the necessity for 30 days postoperatively. It failed to provide documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for post-op cold unit for 30 days in regards to the right wrist is not medically necessary.

**Post-operative physical therapy 2 x week x 4 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10, 16.

**Decision rationale:** California MTUS postoperative guidelines indicate that post-surgical treatment for carpal tunnel syndrome is 3 visits to 8 visits over 3 weeks to 5 weeks, and that the initial therapy should be half of the recommended treatment. Given the above, the request for

post-operative physical therapy 2 times a week x4 weeks would be excessive. There is a lack of documentation indicating exceptional factors to warrant non-adherence to guideline recommendations. As such, the request for post-operative physical therapy 2 x week x 4 weeks is not medically necessary.