

<b>Case Number:</b>	CM13-0034091		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	05/03/2010
<b>Decision Date:</b>	04/09/2014	<b>UR Denial Date:</b>	09/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/11/2013

### 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 & Rehabilitation has a subspecialty Pain Management 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:

This patient reported a date of injury of May 3, 2010. A utilization review determination dated September 23, 2013 recommends noncertification of hot packs purchase and TENS unit purchase, bilateral soft wrist and thumb brace is recommended for certification. An MRI of the right wrist dated March 18, 2012 identifies a subchondral cyst at the distal pole of the scaphoid. A progress report dated August 23, 2013 includes subjective complaints of right shoulder pain, left wrist pain, and right wrist pain. Physical examination identifies reduced range of motion in the right shoulder with tenderness to palpation around the anterior shoulder. The left and right wrist both have painful range of motion with tenderness to palpation around the dorsal wrist and muscle spasm in the forearm. Diagnoses include supraspinatus tendinosis, infraspinatus tendinosis, biceps tendon tendinosis, right shoulder bursitis, right shoulder sprain/strain, left carpal tunnel syndrome, small subchondral cyst in the distal scaphoid bone, ganglion cyst at dorsal aspect of scapholunate joint, and right carpal tunnel syndrome. The treatment plan recommends chiropractic care, TENS unit, hot pack, soft brace, and await NCV/EMG.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HOTPACKS - PURCHASE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 561-563,271-273.

**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);Carpal Tunnel Syndrome Chapter, Cold packs and Heat therapy

**Decision rationale:** Regarding the request for a hot packs, Occupational Medicine Practice Guidelines state physical modalities, such as massage, diathermy, cutaneous laser treatment, "cold" laser treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback have no scientifically proven efficacy in treating acute hand, wrist, or forearm symptoms. Limited studies suggest there are satisfying short- to medium-term effects due to ultrasound treatment in patients with mild to moderate idiopathic CTS, but the effect is not curative. Patients' at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. ODG recommends at-home local applications of cold packs first few days of acute complaints; thereafter, applications of heat therapy. Within the medical information made available for review, there is no indication that the patient has previously used heat therapy, with documentation of efficacy (prior to the purchase of a therapeutic heating device). In the absence of such documentation, the currently requested hot packs are not recommended.

**TENS UNIT - PURCHASE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Page(s): 114-117.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

**Decision rationale:** Regarding the request for TENS, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach, with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Within the documentation available for review, there is no indication that the patient has undergone a TENS unit trial, and no documentation of any specific objective functional deficits which a tens unit trial would be intended to address. Additionally, it is unclear what other treatment modalities are currently being used within a functional restoration approach. In the absence of clarity regarding those issues, the currently requested TENS unit is not medically necessary.