

<b>Case Number:</b>	CM13-0051074		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	02/19/2013
<b>Decision Date:</b>	04/21/2014	<b>UR Denial Date:</b>	09/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2013

### 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 male sustained an injury on 2/19/13 while employed by [REDACTED]. Request under consideration include purchase of hot and cold packs/ wrap and purchase of tens unit. Report of 7/22/13 from the provider noted patient with complaints of constant left wrist pain rated at 8/10 radiating to left forearm, hand, and digits with associated numbness and tingling. Exam of the left wrist/hand showed tenderness to palpation of the carpal bones and wrist joint; range is limited secondary to pain/ positive carpal Tinel's; decreased sensation in the 1st to 3rd digits. Diagnoses included left wrist/hand crush injury/fracture; left forearm cramping; stress; and insomnia. Treatment included chiropractic care with supervised physiotherapy 2x6; acupuncture 2x6; rang of motion and muscle testing; TENS unit and Hot/cold pack/wrap purchase; and Exoten-C lotion. The patient was placed on work restrictions of no use of left hand. The above requests for purchase of TENS unit and Hot and Cold packs/wrap were non-certified 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:

**PURCHASE OF HOT AND COLD PACKS/ WRAP:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 263-266.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm/Wrist/Hand, Cold Packs, and page(s) 157

**Decision rationale:** Per Guidelines regarding Hot/Cold therapy, guidelines state it is "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use". The request for authorization does not provide supporting documentation for purchase beyond the guidelines criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines. The requests for the purchase of the Hot/Cold therapy System with wrap do not meet the requirements for medical necessity. MTUS Guidelines is silent on specific use of hot/cold compression therapy with pad and wrap, but does recommend standard hot/cold pack with exercise. It is not clear from reports provided what specific DME is being requested for purchase. There is no history of surgery noted. The purchase of hot and cold packs/ wrap is not medically necessary and appropriate.

**PURCHASE OF TENS UNIT:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, H-Wave Stimulation Page(s): 115-118.

**Decision rationale:** Per 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 purchase of tens unit is not medically necessary and appropriate.