

<b>Case Number:</b>	CM13-0052860		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	01/19/2012
<b>Decision Date:</b>	06/24/2014	<b>UR Denial Date:</b>	10/31/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2013

### 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, has a subspecialty in Interventional Spine 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:

The patient is a 34-year-old male with date of injury of 01/19/2012. The listed diagnoses per [REDACTED] dated 10/23/2013 are multilevel cervical disk bulge with spinal stenosis and bilateral neuroforaminal narrowing per MRI dated 11/07/2012, sprain /strain of the left shoulder, rotator cuff tendinosis with tear of the infraspinatus, left shoulder per MRA 08/10/2012, degenerative joint disease, left shoulder, lipoma, left subscapular region, sprain/strain, right wrist, old ununited fracture, ulnar styloid process, right wrist, De Quervain's tenosynovitis, right thumb, status post De Quervain's release surgery 09/10/2013, tendonitis, right hand/thumb, tension headache, anxiety and insomnia. According to the report, the patient complains of headaches, left shoulder, right forearm, right wrist and right hand pain. He also notes tingling sensations, sleep interruption, and difficulty falling asleep, depression, and anxiety. The physical exam shows palpation reveals diffuse tenderness over the joint of the right shoulder. Active range of motion is full in all planes with complaints of pain. There is no significant change on the right elbow. Right wrist palpation reveals tenderness over the joint. Range of motion is moderately restricted due to the recent surgery. Finkelstein's test is positive. The utilization review denied the request on 10/31/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CHIROPRACTIC EVALUATION AND TREATMENT ONE (1) TIME A WEEK FOR FOUR (4) WEEKS FOR THE RIGHT WRIST: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58, 59.

**Decision rationale:** This patient presents with chronic left shoulder, right forearm, right hand, and right wrist pain. The provider is requesting chiropractic evaluation and treatment 1 time a week for 4 weeks for the right wrist. The California MTUS Guidelines page 58 and 59 on manual therapy and manipulation states, "recommended for chronic pain if caused by musculoskeletal conditions. Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6 to 8 weeks." However, California MTUS also states that it is not recommended for the forearm, wrist, and hands. In this case, the California MTUS Guidelines do not recommend chiropractic treatments for the forearm, wrist, and hand. Therefore this request is not medically necessary.

**PURCHASE OF A PARAFFIN BATH (HOME USE) FOR THE RIGHT HAND/THUMB:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE: AETNA PARAFFIN BATHS

**Decision rationale:** This patient presents with chronic left shoulder, right forearm, right hand, and right wrist pain. The provider is requesting a purchase of a paraffin bath for home use for the right hand/thumb. The California MTUS, ACOEM, and ODG Guidelines do not address this request; however, AETNA Guidelines on heating devices considers portable paraffin baths medically necessary DME for members who have undergone a successful trial period of paraffin therapy and the member's condition (e.g., severe rheumatoid arthritis of the hands) is expected to be relieved by the long term use of this modality. Standard (non-portable) paraffin baths are not considered appropriate for home use. In addition, paraffin baths are primarily used to treat contractures, particularly for patients with rheumatoid arthritis, hand contractures, or scleroderma. The progress report dated 10/23/2013 notes that the patient has trialed a paraffin bath unit once a day at home which has given him relief of symptoms in the hands including decrease of medication intake and it has provided improvement in his activities of daily living; however, the patient states that his condition has remained the same. In this case, the patient does report significant pain relief from the use of a paraffin bath; however, the AETNA Guidelines recommend this durable medical equipment for patients with rheumatoid arthritis, hand contractures, or scleroderma, which the patient does not present with. Therefore this request is not medically necessary.

**PURCHASE OF A IF4 UNIT (HOME USE) FOR THE LEFT SHOULDER:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS GUIDELINES UNDER INTERFERENTIAL CURRENT STIMULATION (ICS) Page(s): 118-120.

**Decision rationale:** This patient presents with chronic left shoulder, right forearm, right hand, and right wrist pain. The provider is requesting an IF4 unit for home use for the left shoulder. The California MTUS Guidelines page 118 to 120 on interferential current stimulation states, "not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, and medications, and limited evidence of improvement on those recommended treatment alone. There is also insufficient literature to support interferential current stimulation for treatment of conditions including soft tissue injury, wound or fracture healing." In addition, a 1-month trial may be appropriate to permit the provider to study the effects and benefits of its use. The 09/24/2013 report documents, "He reports using the IF4 unit twice a day at home, has given him relief of symptoms in the left shoulder, has lessened the intake of medications, and has provided improvement in activities of daily living. However, he feels his condition has remained the same." In this case, the patient does report relief of symptoms with the use of the IF4 unit; however, he feels that his condition has remained unchanged. While the IF unit has been beneficial, its pain relief appears minimal. Therefore this request is not medically necessary.