

Case Number:	CM13-0065518		
Date Assigned:	01/03/2014	Date of Injury:	12/21/2012
Decision Date:	03/21/2014	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	12/13/2013

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 Orthopedic Surgery 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 an injured worker who sustained injury to the left hand on December 21, 2012. The patient continues to complain of left wrist and forearm pain and weakness. The patient does try to do a home exercise program. On physical examination there is tenderness to palpation of the ulnar side of the wrist and hand. Diagnoses include post burn allodynia in the left upper extremity. Surgery was deemed not to be medically needed. She reports her pain is 8/10 and she is left-hand dominant. The patient continues to have pain and stiffness and limited range of motion. The patient is seen to be a good candidate for a functional restoration program. At issue is whether a wrist rehab kit with moist heat pad and neurostimulator device is medically needed.

IMR ISSUES, DECISIONS AND RATIONALES

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

A wrist rehab kit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: MTUS/AOCCEM Guidelines indicate that there is strong evidence to support the use of exercise programs including aerobic conditioning and strengthening. However, there

is not sufficient evidence to support the recommendation of any particular exercise regimen over any of the recommended exercise program. In addition, the request for rehab kit does not accurately specify the contents of the wrist rehab kit. Furthermore, guidelines do not indicate that wrist rehab kit is better than conventional physical therapy. The request for a wrist rehab kit is not medically necessary and appropriate.

An electric moist heat pad: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM. 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 Official Disability Guidelines (ODG).

Decision rationale: The Official Disability Guidelines (ODG) indicate that at home local applications of heat or cold are as effective as using them with a therapist. ODG guidelines recommend at home local applications of cold pack for the first few days after acute complaints. Thereafter, applications of heat packs are appropriate (after the first 2 days of cold packs) according to guidelines. Given the patient's ongoing complaints of pain, the use of a moist heat pad is appropriate and reasonable based on guidelines. The request for an electric moist heat pad is medically necessary and appropriate.

EMS unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Neuromuscular electrical stimulation (NMES devices) "Not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. (Moore, 1997)(Gaines, 2004) The scientific evidence related to electromyography (EMG)-triggered electrical stimulation therapy continues to evolve, and this therapy appears to be useful in a supervised physical therapy setting to rehabilitate atrophied upper extremity muscles following stroke and as part of a comprehensive PT program." Based on the MTUS guidelines EMS unit treatment is not supported. There is no establishment in medical literature that supports the role of EMS unit in treating chronic wrist pain over conventional measures. EMS unit remains experimental. The request for a EMS unit is not medically necessary and appropriate.

10 electrodes: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Batteries: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Set up and delivery: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.