

<b>Case Number:</b>	CM14-0001728		
<b>Date Assigned:</b>	01/22/2014	<b>Date of Injury:</b>	09/15/2009
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	12/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2014

### 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 Family Medicine 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 is a 65 year old male patient who reported an industrial injury to the wrist on 9/15/2009, over five (5) years ago, attributed to the performance of his customary job tasks. The patient had electrodiagnostic evidence of severe right sided Carpal Tunnel Syndrome (CTS). The patient complained of neck, right shoulder, and bilateral wrist pain. The diagnosis was right CTS and tenosynovitis. The treatment plan included a right wrist CTR and right wrist tenosynovectomy. The Durable Medical Equipment (DME) ordered included the Q-Tech cold recovery system with wrap x 21 days; Q-Tech Deep vein thrombosis (DVT) prevention system x21 days; X-force muscle stimulator with 3 months of supplies; and two conductive garments for the surgical procedure.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Q-TECH COLD THERAPY RECOVERY SYSTEM WITH WRAP TIMES TWENTY-ONE (21) DAYS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 300, 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Knee and leg chapter cold heat packs; continuous flow cryotherpay; Low back chapter cold/head packs.

**Decision rationale:** There is no demonstrated medical necessity for the Motorized hot/cold unit over the recommended cold packs or hot packs. The motorized hot/cold unit is not demonstrated to be medically necessary for home use post operatively. The Motorized hot/cold therapy unit is not medically necessary for the treatment of post-operative pain to the wrist and alternatives for treatment of the wrist are readily available. The request for authorization of the Motorized hot/cold Unit with circulating pads is not supported with objective medically based evidence to support medical necessity. There is no provided objective medically based evidence to support the medical necessity of the motorized hot/cold unit as opposed to the more conventional methods for the application of heat or cold. The CA MTUS, the ACOEM Guidelines, and the ODG recommend hot or cold packs for the application of therapeutic cold or heat. The use of hot or cold is not generally considered body part specific. The Official Disability Guidelines chapter on the knee and lower back states a good example of general use for hot or cold. The issue related to the request for authorization is whether an elaborate mechanical devise is necessary as opposed to the recommended hot or cold pack. The issue is not the body part to be treated but the method of application of heat or cold. It is used as an example that the hot or cold packs are used for treatment and not the mechanical devise in addition to the provided guidelines for the wrist. There is no demonstrated medical necessity for the requested cold unit with wrap for the postoperative treatment of the CTR/tenosynovitis. The request is not medically necessary and appropriate.

**Q-TECH DVT PREVENTION SYSTEM TIMES TWENTY-ONE (21) DAYS:** 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), ODG-TWC, INTEGRATED TREATMENTS/DISABILITY DURATION GUIDELINES, KNEE AND LEG CHAPTER, COMPRESSION GARMENTS.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 300,338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg chapter cold heat packs; continuous flow cryotherpay; Low back chapter cold/head packs.

**Decision rationale:** There is no demonstrated medical necessity for compression therapy post operatively for the prevention of DVT. The patient is noted to have had an initial DVT screening however, there are no documented issues in the medical history of this patient to establish an increased risk for DVT in this patient in relation to the CTR/tenosynovectomy. There is no rationale provided to support the medical necessity of the pneumatic compression devise over compression stockings or wrap for the CTR and tenosynovitis procedure. The Motorized hot/cold therapy unit and Q-Tech DVT prevention system with a wrap is not medically necessary for the treatment of post-operative pain to the wrist and alternatives for treatment of the wrist are readily available. The request for authorization of the Motorized hot/cold Unit with circulating pads and DVT compression is not supported with objective medically based evidence to support medical necessity. There is no provided objective evidence to support the medical necessity of the

motorized hot/cold unit as opposed to the more conventional methods for the application of heat or cold. The concurrent application of intermittent compression to prevent DVT is not demonstrated be medically necessary for the requested 21 days post operatively for the CTR/tenosynovectomy. The request is not medically necessary and appropriate.

**PURCHASE OF X-FORCE STIMULATOR UNIT PLUS THREE (3) MONTHS OF SUPPLIES:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,Chronic Pain Treatment Guidelines electrotherapy ;interferential current stimulation Page(s): 115,118-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) lower back chapter-interferential therapy; pain chapter-interferential current stimulation.

**Decision rationale:** The patient has chronic UE pain reportedly due to RSI that was treated with a CTR and tenosynovectomy. The 4-Lead TENS unit is not recommended by the CA MTUS over the use of the 2-Lead TENS unit. There is no demonstrated medical necessity for the prescription of the X-force muscle stimulator and conductive garments for the treatment of post-operative pain to the wrist.The treating physician provided no subjective/objective evidence to support the medical necessity of the X-Force Unit for the treatment of the patient's postoperative wrist pain. The treating physician has provided no rationale supported with objective evidence to support the medical necessity of the X-force muscle stimulator with two conductive garments and override the recommendations of the California MTUS. The request is not medically necessary and appropriate.

**CONDUCTIVE GARMENT TIMES TWO (2):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,Chronic Pain Treatment Guidelines transcutaneous electrotherapy ; interferential current stimulation Page(s): 115 ,114-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter--TENS units; lower back chapter-interferential therapy; pain chapter-interferential current stimulation.

**Decision rationale:** The provider has provided no rationale supported with objective evidence to support the medical necessity of the X-force muscle stimulator with two conductive garments and override the recommendations of the California MTUS. The X-Force muscle stimulator is not medically necessary post operatively and therefore there is no medical necessity for the requested conductive garments.