

<b>Case Number:</b>	CM14-0120658		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	07/05/2012
<b>Decision Date:</b>	10/02/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2014

### 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 Occupational 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:

The patient is a 32-year-old male who has submitted a claim for wrist sprain associated with an industrial injury date of July 5, 2012. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of pain and discomfort in the left wrist described as burning. There was difficulty with twisting and turning. The patient also had difficulty sleeping and staying asleep due to numbness. Examination revealed tenderness over the triangular fibrocartilage complex of the left wrist, crepitation and clicking sign, and tenderness over the medial epicondyle of the left elbow. Treatment to date has included medications including multiple analgesics. Utilization review from June 24, 2014 denied the request for X-Force stimulator unit, Plus 3 month supplies, Conductive garment (x2)-purchase, TENS unit-purchase and Solar care heating system-purchase. The request for X-force stimulator unit was denied because there was no indication that the device will be used as an adjunct with a home exercise program. The request for TENS unit was denied because there was no indication that the patient had a TENS unit trial in the past with evidence of functional improvement from prior modality use. The request for solar care heating system was denied because there was no clear indication for the specialized device being requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X-Force stimulator unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation Page(s): 117-118.

**Decision rationale:** As stated on pages 117-118 of CA MTUS Chronic Pain Medical Treatment Guidelines, H-wave stimulation (HWT) is not recommended as an isolated intervention, but a trial may be considered as a non-invasive conservative option for chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration. There is no evidence that H-Wave is more effective as an initial treatment when compared to TENS for analgesic effects. In this case, there is no evidence that the request will be used as an adjunct to a program of evidence-based functional restoration. There is likewise no documentation of a rationale, and short-term and long-term treatment plan from the physician with the use of H-wave. Moreover, the request failed to specify if the device is for rental or purchase. Therefore, the request for X-Force stimulator unit is not medically necessary.

**Plus 3 month supplies:** 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.

**Conductive garment (x2)-purchase):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation Page(s): 114-116.

**Decision rationale:** The related requests for TENS unit and stimulator unit have been deemed not medically necessary; therefore, all of the associated services, such as this request for conductive garment x 2 is likewise not medically necessary.

**TENS unit-purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Chronic pain (Transcutaneous electrical nerve stimulation).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation Page(s): 114-116.

**Decision rationale:** As stated on page 114-116 of the California MTUS Chronic Pain Medical Treatment guidelines, TENS units are 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. In this case, there is no evidence that the patient had a one-month trial of TENS use which provided significant relief enough to justify long-term use and purchase of a TENS unit. Therefore, the request for TENS unit-purchase is not medically necessary.

**Solar care heating system-purchase:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Infrared therapy

**Decision rationale:** CA MTUS does not specifically address infrared therapy (IR). Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and the Official Disability Guidelines (ODG) was used instead. ODG states that infrared therapy is not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute low back pain but only as an adjunct to a program of evidence-based conservative care. In this case, it is not clear whether a program of evidence-based conservative care was offered to the patient. The duration of intended use and body part to be treated were not identified in the request. Furthermore, there was no rationale provided as to why a purchase of the device was requested as opposed to a rental. Therefore, the request for Solar care heating system-purchase is not medically necessary.