

<b>Case Number:</b>	CM14-0135435		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	05/12/2014
<b>Decision Date:</b>	09/30/2014	<b>UR Denial Date:</b>	07/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/23/2014

### 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 Internal Medicine, has a subspecialty in Pulmonary Diseases 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 injured worker is a 48-year-old female who reported an injury on 05/12/2014. The mechanism of injury was not provided. On 06/26/2014, the injured worker presented with bilateral hands and wrists pain with numbness, especially at night. Upon examination, range of motion values for the bilateral wrists were 50 degrees of extension, 60 degrees of palmar flexion, 40 degrees of ulnar deviation, and 15 degrees of radial deviation. There was slight pain with range of motion. There was a positive bilateral Phalen's. The diagnosis was bilateral carpal tunnel syndrome. Prior therapy included medications. The provider recommended an X-force stimulator unit and a bilateral thumb splint. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 DURABLE MEDICAL EQUIPMENT X-FORCE STIMULATOR UNIT PURCHASE QTY 1: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119.

**Decision rationale:** The request for a durable medical equipment X-force stimulator unit purchase QTY: 1 is not medically necessary. California MTUS Guidelines do not recommend an X-force stimulation unit as an isolated intervention. There is no quality evidence of effectiveness, except in conjunction with recommended treatments including return to work, exercise, and medications. It may be recommended if pain is ineffectively control by medication, medication intolerance, history of substance abuse, significant pain from postoperative conditions which limit the ability to perform exercise programs/physical therapy treatment, or unresponsive to conservative measures. There is a lack of evidence in the documentation provided that would reflect diminished effectiveness of medications, history of substance abuse, or any postoperative conditions which would limit the injured worker's ability to perform exercise programs/physical therapy treatment. The provider's request does not indicate the site at which the X-force stimulator unit was indicated for in the request as submitted. As such, medical necessity has not been established.

**DURABLE MEDICAL EQUIPMENT SUPPLIES FOR THREE MONTHS FOR X-FORCE STIMULATOR UNIT QTY 3: Upheld**

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

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

**Decision rationale:** The request for durable medical equipment supplies for 3 months for X-force stimulator unit QTY: 3 is not medically necessary. As the primary request for an X-force stimulator is not medically necessary, the associated request is not medically necessary.

**DURABLE MEDICAL EQUIPMENT CONDUCTIVE GARMENT, TIMES TOW, FOR X-FORCE STIMULATOR UNIT QTY 2: Upheld**

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

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

**Decision rationale:** The request for durable medical equipment supplies for 3 months for X-force stimulator unit QTY: 3 is not medically necessary. As the primary request for an X-force stimulator is not medically necessary, the associated request is not medically necessary.

**DURABLE MEDICAL EQUIPMENT PRO-THUMB SPICA SPLINT, FOR BILATERAL THUMBS QUANTITY:2: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 263.-264..

**Decision rationale:** The California MTUS/ACOEM Guidelines state the use of a wrist and thumb splint is indicated for de Quervain's syndrome or carpal tunnel syndrome. There are no specific objective findings that meet the clinical criteria for the use of a thumb spica splint. There are no subjective or objective findings that reference any deficits related to the thumb. As such, medical necessity has not been established.