

Case Number:	CM14-0156398		
Date Assigned:	09/26/2014	Date of Injury:	07/09/2013
Decision Date:	10/27/2014	UR Denial Date:	09/04/2014
Priority:	Standard	Application Received:	09/24/2014

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 Physical Medicine and Rehabilitation, Pain Management 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 42-year-old female with a date of injury of 07/09/2013. The listed diagnoses per [REDACTED] are: 1. Musculoligamentous sprain/strain, cervical spine. 2. Possible medial and lateral epicondylitis, bilateral elbows, right greater than left. 3. Bilateral carpal tunnel syndrome. 4. Sprain/strain, bilateral wrists. According to progress report 05/20/2014, the patient presents with complains of cervical spine, bilateral wrists and hands, bilateral shoulders, and bilateral elbow pain. This patient underwent a partial amputation of the right great toe for a bone infection in 2013. Examination of the cervical spine revealed tenderness to palpation over the cervical spinous processes at C2 to C7. Range of motion was decreased on all planes. There was pain and spasm with flexion, extension, left lateral bending, and left lateral rotation of the cervical spine. Examination of the shoulder revealed tenderness in the acromioclavicular joint, coracoid process, coracoacromial ligament, and long head of biceps on the right. Bilateral Neer's test was positive and Hawkins test was positive on the right only. Examination of the hands and wrist revealed the patient is wearing bilateral wrist braces. There was tenderness noted in the medial and lateral epicondyle, olecranon process, radial head, ulnar styloid, and radial styloid. The treating physician is requesting authorization for right carpal tunnel release along with postoperative PT and durable medical equipments. Utilization Review denied the request on 09/04/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

■■■■ Cold Therapy recovery system with wrap (6-8 hours or as needed): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120-7. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Hand /wrist chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Guidelines, under the Shoulder chapter, continuous-flow cryotherapy

Decision rationale: This patient presents with continued upper extremity complaints. She is experiencing pain in both her hands especially in the right wrist that radiates to the right elbow. The treater is requesting ■■■■ cold therapy recovery system 21 days 6-8 hour per day following the carpal tunnel release. Review of the medical file indicates the patient underwent a right carpal tunnel release on 08/14/2014. Utilization Review denied the request stating "there is no clear explanation on the purchase of these DMEs for a simple outpatient carpal tunnel release." ODG Guidelines, under the Shoulder chapter, has the following regarding continuous-flow cryotherapy: "Recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use." In this case, the treater has recommended this therapy for 21 days. Given the above the request is not medically necessary.

Pro-sling purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines under the wrist/forearm chapter, sling

Decision rationale: This patient presents with continued upper extremity complaints. The treating physician is requesting a Pro Sling purchase for the patient to utilize following her right carpal tunnel release. The ACOEM, MTUS and ODG do not discuss pro slings following carpal tunnel surgery. Shoulder sling is recommended for rotator cuff surgery, AC joint strain/separation, clavicular and scapular fracture treatments, and other fractures per ACOEM page 204. ODG guidelines under the wrist/forearm chapter, only discusses the use of slings in a context of a fracture. This patient does not present with any of these conditions. Given the above the request is not medically necessary.

Wrist CPM with pads for 30 day rental: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG under its wrist/hand chapter regarding Continuous passive motion devices

Decision rationale: This patient presents with continued upper extremity complaints. The treating physician is requesting a wrist CPM with pads for 30-day rental. The ACOEM and MTUS guidelines do not discuss Continuous passive motion (CPM) devices for carpal tunnel syndrome. ODG under its wrist/hand chapter regarding Continuous passive motion devices states, "Recommended. Controlled mobilization regimens are widely employed in rehabilitation after flexor tendon repair in the hand. One trial compared continuous passive motion (CPM) with controlled intermittent passive motion (CIPM) and found a significant difference in mean active motion favoring CPM. (Thien-Cochrane, 2004)" ODG supports the use of CPM following flexor tendon repair but no discussion is provided regarding CTR. Recommendation cannot be made as the guidelines do not provide support for CPM use following CTR. Given the above the request is not medically necessary.

stimulator unit, plus 3 months supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices); TENS unit Page(s): 121; 116.

Decision rationale: This patient presents with continued upper extremity complaints. The treating physician is requesting an stimulator unit for 3 months. stimulator is a combination of TENS and EMS. The MTUS guidelines p121 under Neuromuscular electrical stimulation (NMES devices) states it is 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. Per MTUS Guidelines page 116, TENS unit have not proven efficacy in treating chronic pain and is not recommended as a primary treatment modality but a one-month home-based trial may be considered for specific diagnosis of neuropathy, CRPS, spasticity, phantom-limb pain, and multiple scoliosis. In this case, NMES is not supported for chronic pain. Therefore, recommendation for the combo unit cannot be made. Given the above the request is not medically necessary.

Conductive garment x (2) TENS unit with supplies with built in joint stimulation 30 day rental with possible purchase- right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 116.

Decision rationale: This patient presents with continued upper extremity complaints. The treating physician is requesting a TENS unit with 2 conductive garment and built-in joint stimulation for a 30-day rental with possible purchase. Utilization review denied the request stating, "No clinical findings to support need for this DME." Per MTUS Guidelines 116, TENS unit have not proven efficacy in treating chronic pain and is not recommended as a primary treatment modality but a one-month home-based trial may be considered for specific diagnosis of neuropathy, CRPS, spasticity, phantom-limb pain, and multiple scoliosis. The MTUS Guidelines page 116 states "form-fitting TENS device is only considered medically necessary when there is documentation that there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment, that the patient has medical condition such as skin pathology that prevents the use of the traditional system or the TENS unit is to be used under a cast (as in treatment for disuse atrophy)." In this case, the patient meet the indications for a 30 day trial of a TENS unit, but the patient does not have any medical conditions that would warrant a specialized conductive garment or build-in joint stimulation. Given the above the request is not medically necessary.