

<b>Case Number:</b>	CM14-0036553		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	03/03/2011
<b>Decision Date:</b>	08/07/2014	<b>UR Denial Date:</b>	03/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/25/2014

### 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 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 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 50 year old female claimant with an industrial injury dated 05/16/13. Prior treatments include left wrist carpal tunnel cortisone injections on 09/10/13 and on the right wrist on 10/17/13. Patient is status post electromyogram and nerve conduction velocity studies of the bilateral upper extremities on 09/11/12 which documented mild carpal tunnel syndrome. Exam note 02/06/14 states patient returns with complaints of low back pain radiating to the lower extremities and numbness in wrists. Patient was diagnosed with bilateral wrist tendinitis, bilateral mild carpal tunnel syndrome, and right de quervain's tenosynovitis. Approval from utilization review on 3/21/14 is made for bilateral carpal tunne releases.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative rehabilitation therapy, 3 times a week for 4 weeks, QTY: 12:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16.

**Decision rationale:** Per the CA MTUS/Post Surgical Treatment Guidelines, page 16, 3-8 visits over a 3 month period is authorized. From the submitted records the request is greater than the 8

allowable. In addition, is initially recommended per the Post Surgical Treatment Guidelines. Therefore the request for post-operative rehabilitation therapy, 3 times a week for 4 weeks, QTY: 12 is not medically necessary and appropriate.

**Coolcare cold therapy unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome (updated 2/2014).

**Decision rationale:** Per ODG Carpal Tunnel Syndrome, Continuous cold therapy, is recommended as an option in the postoperative setting with use no more than 7 days. The request does not specify amount of time Therefore, the request for Coolcare cold therapy unit is not medically necessary and appropriate.

**Post-operative home health care assistance, 8 hours daily, 7 days a week for 2 weeks, then 4 hours daily, 3 days a week for 4 weeks following each surgical intervention: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.guideline.gov/content.aspx?id=39387>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Home health services.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of home health services. According to the ODG Pain section, Home health services, Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. In this case the exam notes do not demonstrate the patient is homebound to require the utilization of home health services. Therefore, the request for post-operative home health care assistance, 8 hours daily, 7 days a week for 2 weeks, then 4 hours daily, 3 days a week for 4 weeks following each surgical intervention is not medically necessary and appropriate.

**post-operative OrthoStim unit 4, QTY: 90 days: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation website of VQ OrthoCare.

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

**Decision rationale:** Regarding the Postoperative OrthoStim unit, Interferential Current Stimulation (ICS), the California MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, pages 118-119 state, Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. Therefore, the request for post-operative OrthoStim unit 4, QTY: 90 days is not medically necessary and appropriate.