

<b>Case Number:</b>	CM14-0103103		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	02/03/2012
<b>Decision Date:</b>	12/14/2015	<b>UR Denial Date:</b>	06/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/03/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Oregon  
 Certification(s)/Specialty: Plastic Surgery, Hand Surgery

### 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 45 year old female with a date of injury on 02-03-2012. The injured worker is undergoing treatment for bilateral carpal tunnel syndrome greater on the right side. A physician progress note dated 06-03-2014 documents the injured workers exam reveals right wrist positive Finkelstein's test, and positive Durkin's and Tinel's testing for carpal tunnel syndrome. Her left wrist shows tenderness along the volar aspect of the forearm from the musculotendinous junction down through the palm of the hand. There is a positive Durkin's test. There is no documented conservative treatment or studies for carpal tunnel syndrome present in documents submitted. She is not working. The treatment plan includes a right carpal tunnel release, pre-op clearance, post-op durable medical equipment and a follow up in 4 weeks. The Request for Authorization include 2 Smart glove wrist braces for purchase, IFC unit and supplies, Exercise kit, Micro cool cold therapy unit, Motorized compression pump, and a Transcutaneous Electrical Nerve Stimulation unit and supplies. On 06-27-2014 Utilization Review non-certified the request for 2 Smart glove wrist braces for purchase, IFC unit and supplies, Exercise kit, Micro cool cold therapy unit, Motorized compression pump, and a Transcutaneous Electrical Nerve Stimulation unit and supplies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **2 Smart glove wrist braces for purchase: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG carpal tunnel glove.

**Decision rationale:** Per ODG: Gel-padded glove, not recommended. Gel-padded glove is shown not to be positive. ODG does not support gloves for hand conditions such as carpal tunnel. There is no evidence to show improved outcomes with a glove. The request is not medically necessary.

## **Micro cool cold therapy unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Summary.

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Physical Methods.

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS), 2009, American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Second Edition, 2004, Forearm, Wrist, and Hand Complaints, page 265: "patients at-home applications of heat or cold packs may be used before or alter exercises and are as effective as those performed by a therapist. This patient does not require a specialized cooling unit. Cold packs can be used following surgery as needed for pain and swelling control. The request is not medically necessary."

## **IFC unit and supplies: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Summary.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment.

**Decision rationale:** According to Chapter 3 of ACOEM, Initial Approaches to Treatment, Physical Methods of ACOEM states 'electrical stimulation can keep symptoms at bay temporarily, diminishing pain long enough so that patients begin to mobilize." According to the ODG guidelines, "Interferential stimulation for pain is: "...Possibly appropriate for the following conditions: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative or acute conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)" This patient has pain that is ineffectively controlled

with medications. IF is a non-narcotic approach to pain management that is supported by both ODG and ACOEM. The request is medically necessary to manage her pain.

**TENS unit and supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Summary.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** Rental. Per the MTUS guidelines, "Transcutaneous electrotherapy," page 114, TENS is 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. The patient has neuropathic pain. MTUS supports only a rental with a one month trial. The request does not clearly specify that a rental and one month trial is planned. The request is not medically necessary due to lack of specificity.

**Motorized compression pump:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Summary.

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Physical Methods.

**Decision rationale:** Per ACOEM: Physical modalities, such as massage, diathermy, cutaneous laser treatment, "cold" laser treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback have no scientifically proven efficacy in treating acute hand, wrist, or forearm symptoms. Limited studies suggest there are satisfying short- to medium-term effects due to ultrasound treatment in patients with mild to moderate idiopathic CTS, but the effect is not curative. Patients-at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. ACOEM does not support physical modalities. A motorized compression pump has no proven efficacy in the management of hand conditions. The request is not medically necessary.

**Exercise Kit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Summary.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment.

**Decision rationale:** The patient has chronic pain. According to the California MTUS guidelines, "There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise.

There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated. Such programs should emphasize education, independence, and the importance of an on-going exercise regime." Documentation provided for review does not suggest what the home exercise kit for the hands consists of. While it is acknowledge that this patient needs additional treatment and that a home exercise kit could be beneficial, without documentation of what the "kit" consists of, the request is not medically necessary.