

<b>Case Number:</b>	CM14-0202600		
<b>Date Assigned:</b>	12/15/2014	<b>Date of Injury:</b>	10/08/2012
<b>Decision Date:</b>	01/30/2015	<b>UR Denial Date:</b>	11/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2014

### 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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in New York. 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:

According to the medical records made available for review, the injured worker is a 28 year-old female with a date of injury of 10/08/2012. The results of the injury included injury to the left hand and wrist. Diagnoses include extensor tendinitis of the right wrist, De Quervain's syndrome on the right, status-post surgery, status-post crush injuries to the left fingers-resolved, and De Quervain's syndrome on the left and tendonitis, left wrist-resolved. Diagnostic studies were not made available for review. Treatments have included medications, wrist splints, surgical intervention, post-operative occupational therapy treatments, and steroid injection. Medications have included Motrin, Voltaren, Protonix, Norco, and topical ointments. Surgical intervention, performed on 05/14/2014, consisted of right wrist synovectomy with release of the first dorsal compartment. A post-surgical progress note from the treating physician, dated 05/27/2014, noted the injured worked to be initiated on postoperative therapy. Work status at this time is documented as temporary total disability. Upon completion of 8 occupational therapy visits, documentation from the treating therapist, dated 08/29/2014, reports that the injured worker has increased strength and range of motion; is slow to progress with decreased pain and increased functional use of the right hand; and continues to have numbness and tingling in all digits, bilateral hands at night. A progress note from the treating physician, dated 09/09/2014, documents a follow-up evaluation of the injured worker. The injured worker reported some residual aching in her right wrist associated with weakness. Objective findings consisted of unrestricted thumb and wrist range of motion; some residual tenderness and sensitivity along the radial margin of the wrist; mild diffuse tenderness and swelling along the dorsal right forearm; 50% strength deficit with Jamar testing; and negative Finkelstein sign. Work status is documented as modified duties status with restrictions. The plan of care documented involved six additional therapy sessions concentrating on strengthening and transitioning to a home

exercise program. Request is being made for ART Muscle Stim with garment. On 11/20/2014, Utilization Review non-certified a prescription for ART Muscle Stim with garment. Utilization Review non-certified a prescription for ART Muscle Stim with garment based on lack of evidence of a TENS trial; and no treatment plan was submitted for review. The Utilization Review cited the CA MTUS Chronic Pain Medical Treatment Guidelines: Criteria for the use of TENS. Application for independent medical review was made on 12/03/2014.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**ART Muscle Stim with garment:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114.

**Decision rationale:** The requested TENS is not medically necessary . Per California MTUS Guidelines it is not recommended as an isolated therapeutic intervention and is only recommended on a one-month trial if it is part of a comprehensive rehabilitation program. There is no documentation indicating that the claimant is part of such a rehabilitation program. There is no report of functional benefit from electrical stimulation under the supervision of a licensed physical therapist. Medical necessity for the requested item has not been established. The requested treatment is not medically necessary.