

<b>Case Number:</b>	CM15-0061037		
<b>Date Assigned:</b>	04/07/2015	<b>Date of Injury:</b>	05/04/2001
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	02/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/31/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### 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 60 year old female, who sustained an industrial injury on May 4, 2001. The injured worker was diagnosed as having status post cervical spine discectomy with arthrodesis and instrumentation, status post bilateral shoulder rotator cuff repair, bilateral tendonitis and carpal tunnel syndrome, herniated lumbar disc - status post lumbar epidural steroid injection, chronic pain, acute anxiety and depression, right elbow epicondylitis, and insomnia. Treatment to date has included MRIs, a home paraffin wax unit, bilateral wrist braces, non-steroidal anti-inflammatory injections, lumbar epidural steroid injection, urine drug screening, and medications including oral pain, topical pain, anti-epilepsy, sleep, proton pump inhibitor, and non-steroidal anti-inflammatory. On December 23, 2014, the injured worker complained of pain of the cervical spine, shoulders, and lumbar spine. The physical exam revealed decreased lumbar range of motion, positive straight leg raise with pain at the L5-S1 dermatomal distribution, hypoesthesia at the anterolateral aspect of the foot and ankle, bilateral great toe dorsiflexor and plantar flexor weakness, and paraspinal tenderness with spasms. The treatment plan includes bilateral wrist braces, paraffin wax treatment, and electrodes for an inferential unit. There was no Request for Authorization Form submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Wrist Support Purchase: 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): 265-266.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state when treating with a splint in carpal tunnel syndrome, scientific evidence supports the efficacy of neutral wrist splints. Splinting should be used at night and may be used during the day depending upon activity. In this case, the injured worker does maintain a diagnosis of carpal tunnel syndrome. However, there is no documentation of a significant functional deficit upon examination. The medical necessity for the requested durable medical equipment has not been established. As such, the request is not medically appropriate at this time.

**Batteries: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118,120.

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

**Decision rationale:** As the injured worker's interferential unit has not been authorized, the associated request is not medically necessary.

**Electrodes X 4 Packs: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118,120.

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

**Decision rationale:** As the injured worker's interferential unit has not been authorized, the associated request is not medically necessary.

**IF Unit X 2 Month Rental: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

**Decision rationale:** The California MTUS Guidelines state that interferential current stimulation is 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. There should be documentation that pain is ineffectively controlled due to the diminished effectiveness of medications or side effects, a history of substance abuse or significant pain from postoperative conditions. In this case, there was no documentation of a failure of first line treatment to include TENS therapy. There is no evidence of a successful one month trial prior to the request for a two month rental. The medical necessity has not been established in this case. As such, the request is not medically necessary.