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| Case Number: | CM13-0041502 | | |
| Date Assigned: | 01/15/2014 | Date of Injury: | 02/01/2012 |
| Decision Date: | 06/02/2014 | UR Denial Date: | 10/04/2013 |
| Priority: | Standard | Application Received: | 10/11/2013 |

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 Neurology, has a subspecialty in Neuromuscular Medicine 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:

██████████ is a 43-year-old woman who sustained a work related injury on February 01 2012. She developed a sharp pain in her left wrist. Her Pain radiated towards her left shoulder. The patient's x-rays of the right and left wrist, cervical spine, and thoracic spine were essentially normal. The patient did have an EMG and nerve conduction study of the upper and lower extremities, which were normal. Her physical examination showed limited range of motion of the left hand. She has pain to palpation and muscles/spasm of the left hand. According to the notes of July 16, 2013, her physical examination demonstrated tenderness involving the long head of the left biceps. She was diagnosed with biceps tendinitis of the left shoulder, rotator cuff tendinitis and extensor tendinitis at the level of the left wrist. The provider requested authorization for DME.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: HOT/COLD CONTRAST SYSTEM WITH DVT/COMPRESSION UNIT: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 173-174; 203. Decision based on Non-

MTUS Citation Official Disability Guidelines (ODG), Neck, Continuous-flow cryotherapy (online version).

Decision rationale: According to MUTUS guidelines, DME HOT/COLD therapy is recommended for a short term after surgery. According to ODG guidelines, Continuous-flow cryotherapy, requested treatment is not recommended in the neck. It is recommended as an option after shoulder surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The date of injury was in 2012 and there is documentation of recent surgery in the patient file. Therefore, DME: Hot/Cold Contrast System with DVT/Compression unit is not medically necessary.