

<b>Case Number:</b>	CM13-0044724		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/23/2012
<b>Decision Date:</b>	12/19/2014	<b>UR Denial Date:</b>	10/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2013

### 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 Orthopedic Surgeon 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 injured worker is a 49-year-old male who reported an injury on 04/23/2012. The mechanism of injury was not provided. On 09/09/2013, the injured worker presented for preoperative consultation for the right hand. His physical examination was unremarkable. The diagnoses were diabetes and hypertension. Prior therapies were not noted. The provider recommended a cold therapy unit 30 day rental and a pad purchase; the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold Therapy Unit 30 day rental:** 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)-TWC Forearm, Wrist and Hand Procedure Summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg, Continuous Flow Cryotherapy.

**Decision rationale:** The Official Disability Guidelines recommend cold therapy units as an option after surgery for up to 7 days including home use. The request for a cold therapy unit 30

day rental exceeds the guideline recommendations. The site at which the cryotherapy unit was indicated for was not in the request as submitted. As such, medical necessity has not been established. Therefore, the request is not medically necessary.

**Pad Purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.