

<b>Case Number:</b>	CM13-0047918		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	06/11/2010
<b>Decision Date:</b>	02/28/2014	<b>UR Denial Date:</b>	10/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation 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 physician 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:

This 39-year-old male was injured on 06/11/10, sustaining injuries to the right upper extremity during an explosion. A recent clinical assessment dated 09/05/13, gave the diagnoses of lumbar spine disc protrusion; thoracic spine strain; left wrist ulnar styloid fracture; right hand third and fourth metacarpal status post open reduction internal fixation; bilateral carpal tunnel syndrome; rib fracture(s); blunt chest trauma; headaches, dizziness, and disequilibrium; blurred vision and eye issues; acute hearing loss; and alleged sleep disorder and gastrointestinal (GI) complaints. In regard to the patient's hand complaints, the assessment of 09/05/13 indicated continued numbness and tingling particularly to the right hand with physical examination findings showing positive Phalen's and Tinel's tests to the right hand with diminished sensation to the radial three digits. Electrodiagnostic study reports were not available for review. The treating physician stated that there was evidence of mild to moderate carpal tunnel syndrome on the right. No documentation of clinical findings. At present, there was a surgical request in the form of a right wrist carpal tunnel release, 12 sessions of postoperative physical therapy, and a cryotherapy device to the right wrist. At issue for medical necessity is the request for Cold therapy unit for the right wrist, undetermined duration.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy unit for the right wrist-undetermined duration:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome (Acute & Chronic) Cold Pack; and ODG-TWC-Knee & Leg (Acute & Chronic) Continuous-flow cryotherapy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome (Acute & Chronic) Cold Pack; and ODG-TWC-Knee & Leg (Acute & Chronic) Continuous-flow cryotherapy.

**Decision rationale:** With respect to the request for Cold therapy unit (a cryotherapy device) for the right wrist, this request would not be supported since the guidelines would support the role of a cryotherapy device, post-operatively for "no more than seven days including home use." The predicated surgical procedure was not approved, therefore the request for Cold therapy Unit for the right is not medically necessary.