

Case Number:	CM13-0057252		
Date Assigned:	12/30/2013	Date of Injury:	07/17/2011
Decision Date:	05/30/2014	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	11/25/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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 52 year old female who reported an injury on 07/17/2011. The mechanism of injury was repetitive movement. The clinical note dated 10/18/2013 showed the injured worker complained of ulnar side pain status post ulnar wafer resection. Upon physical examination there was noted tenderness over the triangular fibrocartilage complex and a positive grind test. The injured worker was diagnosed with right ulnar impaction. The medications noted in the clinical documentation dated 08/14/2013 included ibuprofen. There was no diagnostic imaging or other therapies noted for the injured worker. The request for authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

THE TWO WEEK RENTAL OF A COLD THERAPY UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand, Cold packs.

Decision rationale: The request for the two-week rental of a cold therapy unit is non-certified. The injured worker has a history of right wrist pain with a diagnosis of right ulnar impaction. The CA MTUS and ACOEM Guidelines do not address cold therapy for the wrist. The Official Disability Guidelines do recommend cold packs for at-home applications. However, the request is for a cold therapy unit. There is no indication for the need of a specific unit versus cold packs. Furthermore, there was no frequency or duration for the proposed treatment. Therefore, the request for the two-week rental of a cold therapy unit is non-certified.