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| Case Number: | CM13-0068636 | | |
| Date Assigned: | 01/03/2014 | Date of Injury: | 05/13/2008 |
| Decision Date: | 04/21/2014 | UR Denial Date: | 12/06/2013 |
| Priority: | Standard | Application Received: | 12/19/2013 |

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 Surgery and Hand Surgery 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 patient is a 48-year-old male who reported an injury on 05/13/2008. The mechanism of injury was not specifically stated. The patient is currently diagnosed with right carpal tunnel syndrome, right wrist flexor tenosynovitis, neurapraxia of the right median nerve, and right distal antebrachial fasciitis. The patient was seen by [REDACTED] on 11/22/2013. The patient reported ongoing symptoms in bilateral wrists, right greater than left. The patient also reported weakness. Physical examination revealed markedly positive Tinel's testing with paresthesia extending into the 2nd, 3rd and 4th digits of the right hand. The patient also demonstrated markedly positive Durkan's testing, positive Phalen's testing, and pain extending into the right upper extremity and right shoulder. Treatment recommendations included authorization for a flexor tenosynovectomy with carpal tunnel release of the right upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

THE REQUEST FOR A POST-OPERATIVE COLD THERAPY UNIT FOR THE RIGHT WRIST: 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)

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

Decision rationale: Official Disability Guidelines state continuous flow cryotherapy is recommended as an option after shoulder surgery. Postoperative use generally may be up to 7 days, including home use. There are no guideline recommendations for continuous flow cryotherapy for the wrist. There is also no indication that this patient's procedure has been authorized. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.