

Case Number:	CM14-0004015		
Date Assigned:	04/25/2014	Date of Injury:	02/13/2012
Decision Date:	07/28/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	01/10/2014

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 is licensed to practice in Texas and Georgia. 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 02/13/2012 while working in a warehouse from repetitive use. The injured worker has a history of bilateral hand pain and wrist pain with noted numbness. The injured worker had a diagnosis of bilateral ulnar impaction syndrome. The prior treatment included 12 sessions of occupational therapy from 04/24/2013 to 08/12/2013 and an EMG that revealed normal findings. The MRI revealed bilateral ulnar syndrome. The injured worker's physical examination revealed bilateral positive Tinel's at the wrist and elbow with decreased sensation to the left little finger. The injured worker has no medications that he had taken. The injured worker had a nerve conduction study that revealed worsening of the carpal tunnel syndrome on the right wrist. The treatment plan was for a possible right wrist surgery and cold therapy unit. The rationale for cold therapy was not provided. The authorization was not provided with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & leg, Continuous-flow cryotherapy.

Decision rationale: The request for cold therapy unit is non-certified. The Official Disability Guidelines state that continuous-flow cryotherapy may be recommended as an option up to 7 days after surgery, but not for nonsurgical treatment. The documentation submitted for review indicated that a recommendation was made for surgery. However, it was not shown that the surgery was approved. Additionally, the request failed to include a duration. As such, the request for the cold therapy unit is non-certified.