

<b>Case Number:</b>	CM14-0018824		
<b>Date Assigned:</b>	04/23/2014	<b>Date of Injury:</b>	04/08/2013
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	01/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/14/2014

### 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 Emergency Medicine 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 patient reported with a date of injury 4/8/13. Mechanism of injury is described as a fall onto left wrist while at work. Patient has a diagnosis of left distal radius malunion, left carpal tunnel syndrome and left thumb metacarpal joint irritation. Records reveal that patient had close reduction of and percutaneous pinning and wrist arthroscopy and triangular fibrocartilage complex debridement on 5/8/13 for distal radius fracture. There is noted malunion after the surgery. Multiple medical records from primary treating physician and consultants reviewed. The patient complains of constant numbness and pain to left wrist. The patient was using a brace and has reportedly failed bracing. Objective exam reveals positive Tinel, Phalen's on left wrist. External exam is normal. There is normal range of motion of the wrist. There is no documented atrophy but has noted weakness. An electromyogram (EMG) on 11/15/13 reportedly revealed moderate denervation potentials in left opponens pollicis and adductor pollicis with absent sensory conduction consistent with left moderate-severe carpal tunnel syndrome and mild right ulnar neuropathy. The EMG was also consistent with moderate carpal tunnel syndrome of right wrist. X-ray of left wrist on 10/1/13 reveals healed distal radius/ulnar fracture with remodeling and slight dorsal angulation of distal radius. Patient has reportedly attempted sling/brace, physical therapy and medication with no relief. Patient was to undergo carpal tunnel release surgery and request for the cold therapy was for post-operative care. Utilization review is for purchase of cold therapy unit, cold therapy pad and cold therapy wrap for left wrist (unspecified duration). Prior UR on 1/13/14 recommended non-certification. The review also rejected request for carpal tunnel release surgery and post-carpal tunnel physical medicine therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DURABLE MEDICAL EQUIPMENT MI: PURCHASE OF COLD THERAPY UNIT, COLD THERAPY PAD AND COLD THERAPY WRAP FOR UNSPECIFIED DURATION FOR THE LEFT 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) Carpal Tunnel Syndrome, Continuous Cold Therapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome, Continuous Cold Therapy.

**Decision rationale:** MTUS Chronic pain guidelines and ACOEM guidelines do not adequately have any topics related to this issue. As per Official Disability Guidelines (ODG), Continuous Cold therapy is an option for post-operative pain. There is evidence of decrease in swelling and pain. However, patient does not have any approved surgery for the wrist documented. The device should also not be used for more than 3days and there is no documentation of length of treatment requested. Patient does not meet any indication for the use of a cool therapy unit. It is not medically necessary.