

<b>Case Number:</b>	CM14-0111129		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	02/01/2013
<b>Decision Date:</b>	10/23/2014	<b>UR Denial Date:</b>	06/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/16/2014

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Texas and Ohio. 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 39-year-old female who reported a work related injury on 02/01/2013. The mechanism of injury was not provided for review. The injured worker's diagnoses consisted of wrist sprain/strain. Diagnostic tests included an EMG/nerve conduction study which revealed carpal tunnel syndrome bilaterally on an unspecified date. Upon examination on 06/09/2014, the injured worker complained of pain and numbness to the first 3 fingers of her hands bilaterally. She stated that her pain increased at night and that she indicated continuing to drop objects with her right hand. On physical examination of the hands, it was noted that there was no swelling of deformity. The injured worker was able to make a complete fist, bringing the fingers to the mid palmar crease and completely extended all the fingers. The Phalen's and Tinel's signs were positive bilaterally. Wrist extension and finger flexion was noted to be normal bilaterally. It was also noted that sensation was diminished to the index and middle fingers as well as the thumbs bilaterally. The injured worker's prescribed medications included Ultram and Motrin. The treatment plan consisted of a continuation of medications, authorization for a carpal tunnel release of the right and left hand, request for authorization for physical therapy, request for authorization for a cold unit, and authorization for right wrist brace. A rationale for the request and a Request for Authorization form were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post Operative Therapy with Ultrasound , Massage, & Therapeutic Exercises 3 Times a Week for 4 Weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 15-16.

**Decision rationale:** The request for post-operative therapy with ultrasound, massage, & therapeutic exercises 3 times a week for 4 weeks is not medically necessary. The California MTUS guidelines only recommend 3 to 8 sessions of physical therapy in the postoperative setting. The request for 12 sessions would exceed clinical guidelines and cannot be warranted. As such, the request for the request for post-operative therapy with ultrasound, massage, & therapeutic exercises 3 times a week for 4 weeks is not medically necessary.

**Durable Medical Equipment (DME) -Cold Unit - Right Hand:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The request for durable medical equipment (DME) -cold unit - right hand is not medically necessary. The Official Disability Guidelines do recommend continuous-flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries such as muscle strains and contusions has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Therefore, a continuous flow cryotherapy unit would be supported to decrease pain, inflammation, swelling and narcotic use, however, the duration of time the unit would be used was not specified in the request. As such, the request for a motorized cold therapy unit is not medically necessary.