

Case Number:	CM14-0033366		
Date Assigned:	06/20/2014	Date of Injury:	01/18/2012
Decision Date:	08/25/2014	UR Denial Date:	03/07/2014
Priority:	Standard	Application Received:	03/17/2014

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 and Rehabilitation, has a subspecialty in Pain 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 54 year old whose date of injury is 01/18/2012. The mechanism of injury is described as repetitive work duties. The injured worker reports injuries to the bilateral wrists, cervical spine and lumbar spine. Orthopedic panel qualified medical evaluation dated 02/10/14 indicates that chief complaint is low back pain, bilateral hand numbness and neck pain. Diagnoses are lumbosacral strain without complaints or findings of radiculopathy, cervical strain without radiculopathy, and probable bilateral carpal tunnel syndrome. She has been authorized for right carpal tunnel release.

IMR ISSUES, DECISIONS AND RATIONALES

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

RQ Cold Therapy Unit and Tech Fee Right Wrist (not noted if rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

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 chapter, Continuous cold therapy (CCT).

Decision rationale: Based on the clinical information provided, the request for RQ cold therapy unit and tech fee right wrist is not recommended as medically necessary. The request is

nonspecific and does not indicate if the request is for rental or purchase of the unit. The Official Disability Guidelines note that cold therapy is recommended as an option only in the postoperative setting and up to seven days. The request is not medically necessary.