

Case Number:	CM14-0058805		
Date Assigned:	07/09/2014	Date of Injury:	06/26/2010
Decision Date:	09/12/2014	UR Denial Date:	04/22/2014
Priority:	Standard	Application Received:	04/29/2014

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. 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 56 year old female who was injured on June 26, 2010. The injured worker was lifting chicken skewers and was subsequently diagnosed with cervical thoracic strain with right C8 radiculopathy, right shoulder impingement, left shoulder compensatory injury, mild to moderate right carpal tunnel syndrome, mild left carpal tunnel syndrome, right ulnar nerve neuritis of the cubital tunnel, right lateral epicondylitis and intersection syndrome on the right with first dorsal compartment tendinitis. Treatment to date includes first dorsal compartment injection on 10/10/13, carpal tunnel injection in November 2013, diagnostic testing and medication management. The injured worker was recommended for postoperative cold therapy unit following carpal tunnel release.

IMR ISSUES, DECISIONS AND RATIONALES

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

DURABLE MEDICAL EQUIPMENT MI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

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 durable medical equipment Mi is not recommended as medically necessary. The prior utilization review dated 04/22/14 indicates that the request is for a postoperative cold therapy unit; however, the request submitted is nonspecific. There is no documented frequency and duration of the requested treatment. The Official Disability Guidelines note that postoperative use of cryotherapy would be supported for up to seven days. However, given the lack of a specific request, the request is not medically necessary.