

<b>Case Number:</b>	CM14-0075096		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	06/19/2010
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	05/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/22/2014

### 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 and is licensed to practice in Nevada. 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 records presented for review indicate that this 48 year old female was reportedly injured on June 19, 2010. The mechanism of injury is undisclosed. The most recent progress note, dated April 24, 2014, indicates that there are ongoing complaints of right hand pain and stiffness as well as decreased grip strength. The physical examination demonstrated pain with flexion and extension of the wrist and tenderness along the third and fourth digits, positive Tinel's and Phalen's test, cervical spine revealed decreased cervical spine range of motion, and tenderness along the paravertebral muscles and trapezius, and no pain noted with compression or distraction. Diagnostic imaging studies were not reviewed during this visit. Previous treatment includes a right sided carpal tunnel release. A request was made for the use of a cold therapy unit for seven days, the use of a cold therapy unit for thirty days, and participation postoperative physical therapy three times a week for four weeks and was not certified in the preauthorization process on May 22, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy unit x seven (7) days:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines Shoulder Chapter, Continuous-flow cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous Flow Cryotherapy, Updated August 27, 2014.

**Decision rationale:** According to the Official Disability Guidelines (ODG) the use of continuous flow cryotherapy is recommended as an option after surgery to help decrease pain, inflammation, swelling, and narcotic usage for up to seven days time. As the injured employee has been approved for surgery, this request for a cold therapy unit for seven days is medically necessary.

**Cold therapy unit 30 days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines Shoulder Chapter, Continuous-flow cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous Flow Cryotherapy, Updated August 27, 2014.

**Decision rationale:** According to the Official Disability Guidelines the use of continuous flow cryotherapy is recommended as an option after surgery to help decrease pain, inflammation, swelling, and narcotic usage for up to seven days time. As this request is for thirty days of use, this request for a cold therapy unit for thirty days is not medically necessary.

**Post operative occupational therapy three times a week for four weeks QTY:12:**  
Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** The California Chronic Pain Medical Treatment Guidelines recommends twelve visits of postsurgical treatment for arthropathy of the wrist. As the injured employee has been recommended for surgery for a mobilization of the wrist under anesthesia, this request for twelve visits of postoperative occupational therapy three times a week for four weeks is medically necessary.