

Case Number:	CM15-0009836		
Date Assigned:	01/27/2015	Date of Injury:	01/17/2014
Decision Date:	03/13/2015	UR Denial Date:	12/18/2014
Priority:	Standard	Application Received:	01/16/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 46 year old female who sustained a work related injury January 17, 2014. According to the injured worker, she experienced right elbow pain exacerbated by repetitive activities as a machine operator. Over the course of care, the injured worker was treated with NSAID's (non-steroidal anti-inflammatory drugs) Topical Analgesics, Opioids, physical therapy and steroid injections. Diagnoses included right carpal tunnel syndrome and right lateral epicondylitis. On December 16, 2014, the injured worker underwent carpal tunnel release of the right wrist with flexor tendon tenosynovectomy of the right wrist with intraarticular injection of the right wrist. According to utilization review dated December 18, 2014, the request for Cold Therapy Unit (purchase) is non-certified. The request for IF Unit 1-2 month rental is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: Cold Therapy Unit (purchase): 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), Knee Chapter, Continuous Flow Cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Carpal Tunnel Syndrome (Acute & Chronic)

Decision rationale: The injured worker sustained a work related injury on January 17, 2014. The medical records provided indicate the diagnosis of right carpal tunnel syndrome and right lateral epicondylitis. On December 16, 2014, the injured worker underwent carpal tunnel release of the right wrist with flexor tendon tenosynovectomy of the right wrist with intraarticular injection of the right wrist. The medical records provided for review do not indicate a medical necessity for DME: Cold Therapy Unit (purchase). The MTUS is silent on this in relation to carpal tunnel surgery. The Official Disability Guidelines recommends it as an option only in the postoperative setting for not more than 7 days. Therefore, while it is useful, it is not medically necessary and appropriate to purchase it.

IF Unit 1-2 months Rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS), and TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

Decision rationale: The injured worker sustained a work related injury on January 17, 2014. The medical records provided indicate the diagnosis of right carpal tunnel syndrome and right lateral epicondylitis. On December 16, 2014, the injured worker underwent carpal tunnel release of the right wrist with flexor tendon tenosynovectomy of the right wrist with intraarticular injection of the right wrist. The medical records provided for review do not indicate a medical necessity for IF Unit 1-2 months Rental. The MTUS recommends against using it as an isolated intervention due to lack of evidence showing it's beneficial when used alone. Furthermore, the MTUS recommends that if it is going to be used with other measures, it must satisfy the following conditions; Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). The requested treatment is not medically necessary and appropriate for not meeting the recommendation.