

<b>Case Number:</b>	CM15-0145636		
<b>Date Assigned:</b>	08/06/2015	<b>Date of Injury:</b>	05/29/2013
<b>Decision Date:</b>	09/03/2015	<b>UR Denial Date:</b>	07/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/27/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 58-year-old female who sustained an industrial injury on 5/29/13. Injury occurred relative to repetitive job duties of lifting, cutting, bending and stooping. Past surgical history was positive for an L4/5 anterior and posterior lumbar decompression and fusion on 12/22/14, and subsequent complex wound closure on 2/23/15 due to posterior wound dehiscence. The 6/23/15 treating physician report cited complaints including right finger pain and locking. Physical exam documented tenderness to palpation over the right middle and ring fingers with painful triggering. She was diagnosed with right stenosing of the middle and ring finger. The injured worker had painful triggering of the right middle and ring fingers with range of motion, and had failed therapy, multiple corticosteroid injection, and bracing. The treatment plan recommended trigger finger release surgery. Authorization was also requested for a post-operative cold therapy unit for 7 days. The 7/14/15 utilization review non-certified the request for a post-operative cold therapy unit for 7 days, citing the Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy unit post operative 7 days:** 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).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist & Hand: Cold packs.

**Decision rationale:** The California MTUS are silent regarding cold therapy devices, but recommend at home applications of cold packs for hand complaints. The Official Disability Guidelines recommend at-home local applications of cold packs for first few days of acute hand complaints. There is insufficient evidence to support the efficacy of a cold therapy unit over standard cold packs. Therefore, this request is not medically necessary.