

Case Number:	CM15-0195303		
Date Assigned:	10/09/2015	Date of Injury:	10/24/2014
Decision Date:	11/19/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	10/05/2015

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: Maryland, Virginia, North Carolina
 Certification(s)/Specialty: Plastic 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:

This 22 year old female sustained an industrial injury via cumulative trauma from 10-29-14 to 1-21-15. Documentation indicated that the injured worker was receiving treatment for right hand and wrist pain. Previous treatment included physical therapy, injections, bracing and medications. Magnetic resonance imaging right wrist (8-17-15) showed at least a partial tear of the dorsal band of the scapholunate ligament and a longitudinal split tear of the extensor carpi ulnaris tendon. In a Pr-2 dated 8-20-15, the injured worker complained of persistent locking and instability of the right wrist and hand. The treatment plan included surgical repair of the extensor carpi ulnaris tendon of the right wrist with stabilization and associated surgical services. On 9-9-15, Utilization Review noncertified a request for associated surgical service: cold therapy unit (purchase) and interferential unit (30 day rental).

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: cold therapy unit (purchase): Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Continuous-cold cryotherapy.

Decision rationale: The patient is a 22 year old female who was certified for right wrist arthrotomy and repair of extensor carpi ulnaris tendon. A request had been made for a cold therapy unit purchase. From ODG, Continuous-flow cryotherapy: Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting. His meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is fairly inexpensive, easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of knee surgery. There is limited information to support active vs passive cryo units. Aetna considers passive hot and cold therapy medically necessary. Mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. This study concluded that continuous cold therapy devices, compared to simple icing, resulted in much better nighttime pain control and improved quality of life in the early period following routine knee arthroscopy. Two additional RCTs provide support for use after total knee arthroplasty (TKA). Cold compression reduced blood loss by 32% and pain medication intake by 24%. It improved ROM and reduced hospital stay by 21%. Continuous cold therapy may be indicated but should not exceed 7 postoperative days. Therefore, a cold therapy unit purchase would not be considered consistent with these guidelines and should not be considered medically necessary. In addition, the time course of treatment was not documented.

Associated surgical service: IF unit (30 day rental): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Hand and Wrist Chapter-Electrical Stimulators (E-stim), TENS (Transcutaneous Electrical Neurostimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The patient is a 22 year old female who was certified for right wrist arthrotomy and repair of extensor carpi ulnaris tendon. A request had been made for a 30 day rental of an IF unit. An interferential unit should be considered in the same light as transcutaneous electrotherapy. From pages 116 and 117 of Chronic Pain Medical Treatment

guidelines, this is addressed in the postoperative period. Recommended as a treatment option for acute post-operative pain in the first 30 days post-surgery. Transcutaneous electrical nerve stimulation (TENS) appears to be most effective for mild to moderate thoracotomy pain. It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. The proposed necessity of the unit should be documented upon request. Rental would be preferred over purchase during this 30-day period. Based on the documentation provided in this review, the proposed necessity has not be sufficiently documented and therefore, should not be considered medically necessary.