

Case Number:	CM15-0036265		
Date Assigned:	03/04/2015	Date of Injury:	06/21/2012
Decision Date:	04/14/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	02/26/2015

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: District of Columbia, Virginia
Certification(s)/Specialty: Internal 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 42 year old right hand dominant male, who sustained a work/ industrial injury on 6/21/12. He has reported symptoms of right wrist pain with numbness rated 6/10. The diagnoses have included right carpal sprain/strain, right wrist injury, right wrist internal derangement, and neuralgia. Treatments to date included medication, conservative treatment, diagnostics, and orthopedic consult. Diagnostics included x-ray and Computed Tomography (CT) scan noted minimal osteoarthritis on the surface of the trapezium and bridging of the lunate and triquetrum, congenital anomaly. X-ray of the right hand noted a dorsal angulated fracture of the right fifth metacarpal. Magnetic Resonance Imaging (MRI) of right wrist reported fusion of the lunate and triquetrum, radioulnar joint effusion. The treating physician's report (PR-2) from 1/23/15 indicated pain and tenderness to the right wrist. Examination noted Jamar grip strength testing noted 20/22/20 on the right and 22/24/24 on the left hand. Gripping caused pain in the right wrist. Range of motion was painful. There was tenderness with palpation of the dorsal ulnar wrist, dorsal wrist and volar wrist. Carpal compression caused pain. Reverse Phalen's was positive. There was no visible swelling, atrophy, lesion, or bruising. Treatment plan included hot and cold therapy. On 2/12/15, Utilization Review non-certified a Heat Therapy Unit (2 times/Day for 15-20 minutes), Rental Right Wrist; Cold Therapy Unit (2 times/Day for 15-20mins), Rental Right Wrist, citing California Medical treatment Utilization Schedule (MTUS) Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Heat Therapy Unit (2 times/Day for 15-20 minutes), Rental Right Wrist: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 35, 44.

Decision rationale: Per MTUS ACOEM guidelines, "heat or cold therapy, short-term pharmacotherapy (oral medication), a short period of inactivity, specific recommendations regarding employment and recreational activities, and judicious mobilization and resumption of activity, even before the patient is pain-free." The patient had ongoing pain issues. Per review of the clinical data provided and from guidelines cited above, this therapy would be indicated. This request is medically necessary.

Cold Therapy Unit (2 times/Day for 15-20mins), Rental Right Wrist: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 35, 44.

Decision rationale: Per MTUS ACOEM guidelines, "heat or cold therapy, short-term pharmacotherapy (oral medication), a short period of inactivity, specific recommendations regarding employment and recreational activities, and judicious mobilization and resumption of activity, even before the patient is pain-free." The patient had ongoing pain issues. Per review of the clinical data provided and from guidelines cited above, this therapy would be indicated. This request is medically necessary.