

Case Number:	CM14-0159795		
Date Assigned:	10/03/2014	Date of Injury:	06/01/2011
Decision Date:	02/09/2015	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	09/29/2014

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 Rehab, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 patient is a 50 year-old female with a 6/1/2011 date of injury. According to the 8/25/14 Doctor's First Report, the patient has 5/10 bilateral wrist pain from a cumulative trauma 3/2/04-3/14/2013 industrial injury claim. It is noted that the date of injury on the Doctor's First Report does not match the date of injury on the IMR application. The available records do not document any recent surgical procedures. According to the 9/17/14 handwritten progress report, the patient has 4/10 pain and weakness at the right wrist, 3/10 in the left wrist, 4/10 lumbar pain, right shoulder pain and 0/10 cervical pain. The diagnoses included lumbar radiculitis; sciatica; myospasm; bilateral wrist sprain, r/o CTS On 9/08/14 utilization review reviewed the 8/25/14 medical report and recommended non-certification for a motorized cold therapy unit. The reviewer states there was no indication why the patient could not apply OTC cold packs.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME-Motorized Cold Therapy Unit: 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), Cold Treatments

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, and wrist chapter

Decision rationale: The request is for a motorized cold therapy unit, which is also known as a continuous cold therapy unit. The patient presents with neck, back, bilateral wrist and right shoulder pain. There is no recent surgical history provided. There is no discussion on the cold therapy unit. The records do not indicate what body region this unit will be used on or why it is necessary in the chronic stage of care. The 9/17/14 report requests EMG/NCV to rule out carpal tunnel syndrome. MTUS and ACOEM do not discuss motorized cold therapy units. ODG online, Forearm, and wrist, hand section under the Continuous cold therapy (CCT) topic states: Recommended as an option only in the postoperative setting, with regular assessment to avoid frostbite The patient is not in a postoperative setting and does not meet the ODG criteria for a motorized cold therapy unit. The request for DME-Motorized Cold Therapy Unit is not medically necessary.