

<b>Case Number:</b>	CM14-0210654		
<b>Date Assigned:</b>	12/23/2014	<b>Date of Injury:</b>	03/04/2011
<b>Decision Date:</b>	02/19/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2014

### 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. 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, California  
 Certification(s)/Specialty: Family Practice

### 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 is a 54 years old female patient who sustained an injury on 3/4/2011. She sustained the injury while offloading files from a car. The diagnoses include status post left open cubital tunnel release; status post left open carpal tunnel release; status post exploration of left carpal tunnel; right carpal tunnel syndrome; left cubital tunnel syndrome with negative electro diagnostic study. Per the doctor's note dated 5/1/2014, she had complaints of left wrist and hand pain with tingling and numbness. The physical examination revealed positive direct compression, and hyperflexion, and negative ulnar nerve subluxation for left cubital tunnel; left carpal tunnel- positive Tinel, positive direct compression and Phalen test. The medications list includes norco and flexeril. She has had left wrist MRI dated 12/13/2011 which revealed 2.0 cm Ganglion cyst between the first and second CMC joints that extends into the carpal canal along the volar margin; Electro diagnostics study dated 1/23/2014 which revealed left ulnar neuropathy at the elbow, largely unchanged from prior study 10/12/11; cervical MRI dated 3/14/12 which revealed degenerative disc disease; lumbar MRI dated 2/12/13 which revealed post operative changes and retrolisthesis at L5-S1. She has undergone L4 through S1 level fusion in 2001; right shoulder arthroscopic subacromial decompression, extensive soft tissue debridement of superior labrum anterior and posterior lesion and rotator cuff, open Mumford procedure on 8/21/2013; left open cubital and open carpal tunnel release on 5/5/2014. She has had physical therapy visits and left wrist cortisone injection for this injury.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Kodiak Combo Cold Therapy Unit purchase DOD: 5/6/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Chapter: Shoulder (updated 10/31/14; Continuous-flow cryotherapy; Chapter: Knee & Leg (updated 02/05/15) Continuous-flow cryotherapy

**Decision rationale:** The cited guidelines recommend use of a cold therapy unit for only 7 days post operatively after major shoulder / knee surgeries. Any evidence of such a procedure in 5/2014 was not specified in the records provided. The rationale for not using cold packs was not specified in the records provided. The rationale for not renting a cryotherapy device for temporary postoperative use for 7 days, as recommended in the guidelines, versus requesting a purchase of the device, was not specified in the records provided. Response to other conservative therapy including physical therapy was not specified in the records provided. The medical necessity of Retro Kodiak Combo Cold Therapy Unit purchase DOD: 5/6/14, as submitted, was not fully established for this patient.