

Case Number:	CM14-0033482		
Date Assigned:	06/20/2014	Date of Injury:	03/12/2012
Decision Date:	02/03/2015	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	03/17/2014

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 Emergency Medicine, 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 injured worker is a 35 year-old female who sustained an injury on March 12, 2012. The mechanism of injury occurred from cumulative trauma. Diagnostics have included: April 30, 2012 EMG/NCV reported as showing a normal study. Treatments have included: medications, wrist immobilizer, physical therapy, acupuncture, steroid injection. The current diagnosis is left wrist de Quervain tenosynovitis. The stated purpose of the request for Polar Care Unit Rental was not noted. The request for Polar Care Unit Rental was denied on February 18, 2014, citing a lack of documentation of medical necessity. Per the report dated February 4, 2014, the treating physician noted complaints of left wrist pain. Exam showed left wrist and hand tenderness over the first extensor compartment and a positive Finkelstein test and is planning a left wrist extensor compartment open release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Polar Care Unit Rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Hand/Wrist/Forearm, Continuous Flow Cryotherapy

Decision rationale: The requested Polar Care Unit Rental, is not medically necessary. CA MTUS is silent on this issue and ODG, Hand/wrist/forearm, Continuous Flow Cryotherapy, recommends up to 7 days post-op cold therapy. In a post-operative setting, cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The injured worker has left wrist pain. The treating physician has documented left wrist and hand tenderness over the first extensor compartment and a positive Finkelstein test and is planning a left wrist extensor compartment open release. The treating physician did not document the duration of use of the requested cold therapy unit. The criteria noted above not having been met, Polar Care Unit Rental is not medically necessary.