

Case Number:	CM15-0121047		
Date Assigned:	07/01/2015	Date of Injury:	11/23/2013
Decision Date:	07/30/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/23/2015

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: California, Indiana, Oregon
 Certification(s)/Specialty: Orthopedic 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:

The injured worker is a 47 year old female, who sustained an industrial injury on 11/23/2013. The injured worker reported injuries to the left shoulder, elbow, and wrist that developed gradually secondary to daily work activities. The injured worker was diagnosed as having neck sprain/strain, spasm of muscle, carpal tunnel syndrome, lateral epicondylitis of the elbow, effusion of shoulder joint, sprain/strain of an unspecified site of the shoulder and upper arm, brachial neuritis/radiculitis not otherwise specified, aseptic necrosis of other bone site, enthesopathy of unspecified site, and unspecified disorders of the bursae and tendons of the shoulder region. Treatment and diagnostic studies to date has included at least 4 sessions of physical therapy, laboratory studies, use of a wrist brace, status post left shoulder arthroscopy, chiropractic therapy, functional capacity evaluation, and medication regimen. In a progress note dated 05/07/2015 the treating physician reports complaints of constant pain to the left shoulder and right wrist. Examination reveals decreased range of motion, tenderness, and swelling to the right wrist along with a positive Tinel's test, positive grip strength test, and a positive Phalen's test. The injured worker's pain level is rated a 7 to 8 on a scale of 0 to 10. The treating physician requested a 10 day rental of a cold therapy unit and 12 sessions of post-operative physical therapy for the right hand with the treating physician noting that the injured worker will need a carpal tunnel release, but the medical records provided did not contain he specific reason for the requested treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit, 10 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines Continuous cold therapy (CCT).

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

Decision rationale: This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur. CA MTUS/ACOEM is silent on the issue of cryotherapy for the hand. According to ODG, Forearm, Wrist and Hand, cryotherapy is not recommended. Cold packs are recommended for at home application during first few days and thereafter application of heat. As the guidelines do not recommend cryotherapy for the hand, the request is not medically necessary.

Twelve post operative physical therapy visits: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16.

Decision rationale: This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur. Per the CA MTUS/Post Surgical Treatment Guidelines, page 16, 3-8 visits over a 3 month period is authorized. Half of the visits are initially recommended pending re-evaluation. In this case the request exceeds the initial recommended treatment number and is therefore not medically necessary.