

Case Number:	CM15-0032959		
Date Assigned:	02/26/2015	Date of Injury:	01/01/2011
Decision Date:	06/08/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/23/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 46 year old female, who sustained an industrial injury on 1/1/2011. She reported pain in her neck, right shoulder and low back. Diagnoses have included neck pain, right shoulder pain, right shoulder adhesive capsulitis and possible right carpal tunnel syndrome. Treatment to date has included magnetic resonance imaging (MRI), massage therapy and medication. Per documentation a PR-2 report dated 12/15/14 treatment plan includes bilateral carpal tunnel release with possible flexor tenosynovectomy and or median/neurolysis. According to the report dated 1/8/2015, the injured worker complained of pain in her neck, low back and right shoulder rated 6/10. She reported that neck pain radiated to the right shoulder, scapular region and to the right upper extremity with numbness and tingling in the right hand. Physical exam revealed tenderness in the right acromioclavicular joint. There was decreased range of motion in the cervical spine and dysesthesia noted to light touch in the right C6 dermatome. Authorization was requested for purchase of a cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome (Acute & Chronic)-Continuous cold therapy (CCT).

Decision rationale: Cold therapy unit for purchase is not medically necessary per the MTUS ACOEM Guidelines and the ODG. The MTUS states that patients at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. The ODG states that continuous cold therapy is recommended as an option only in the postoperative setting, with regular assessment to avoid frostbite. Postoperative use of cold therapy units should generally should be no more than 7 days, including home use. The request exceeds guideline recommendations for use of a cold therapy unit for only 7 post op days. It is unclear why the patient cannot use an at home applications of cold packs. The request for a cold therapy unit for purchase is not medically necessary.