

<b>Case Number:</b>	CM15-0040109		
<b>Date Assigned:</b>	03/10/2015	<b>Date of Injury:</b>	09/10/2013
<b>Decision Date:</b>	06/18/2015	<b>UR Denial Date:</b>	02/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2015

### 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

Certification(s)/Specialty: Orthopedic Surgery, Hand Surgery, Sports 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 57 year old male, who sustained an industrial injury on 09/10/2013. He reported immediate pain in his head, neck and lower back. The injured worker was diagnosed as having right elbow cubital tunnel syndrome, bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, lumbar degenerative disc disease, right L5 chronic nerve root irritation, cervical degenerative disc disease and evidence of chronic C7 nerve root irritation on the right side. Treatment to date has included medications, physical therapy, lumbar epidural steroid injection, x-rays, electrodiagnostic testing and carpal tunnel release. Currently, the injured worker complains of numbness, intense pain to the cervical spine with stiffness and limited range of motion, with range of motion and pain in the lumbar spine and right leg numbness. On 02/04/2015, the provider submitted a request for authorization for surgery and associated surgical services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: Cold Therapy Unit Purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation J Shoulder Elbow Surg. 2015 Mar 27. pii: S1058-2746(15)00077-4. doi: 10.1016/j.jse.2015.02.004. [Epub ahead of print] Compressive cryotherapy versus ice-a prospective, randomized study on postoperative pain in patients undergoing arthroscopic rotator cuff repair or subacromial decompression. Kraeutler MJ1, Reynolds KA2, Long C2, McCarty EC2.

**Decision rationale:** The CA MTUS notes that, "Patients' at-home applications of heat or cold are as effective as those performed by a therapist." Randomized studies of commercial cold units versus ice such as the one referenced above have shown no benefit of the commercial units. It is reasonable to apply cold to the surgical site after surgery, but there is no benefit to the cold therapy unit requested over readily available materials such as a bag of ice. Therefore, the cold therapy unit is not medically necessary.

**Associated surgical service: IF Unit x 1 month rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

**Decision rationale:** The CA MTUS notes, "Physical modalities, such as massage, diathermy, cutaneous laser treatment, "cold" laser treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback have no scientifically proven efficacy in treating acute hand, wrist or forearm symptoms." In the Chronic Pain guidelines it is noted that interferential current stimulation is, "Not recommended as an isolated intervention." and "There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." Therefore, the IF unit is not medically necessary.