

<b>Case Number:</b>	CM15-0074673		
<b>Date Assigned:</b>	04/27/2015	<b>Date of Injury:</b>	03/25/2011
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	03/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/20/2015

### 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: New York, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency 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 31 year old female who sustained an industrial injury on 03/25/2011. Current diagnoses include left wrist status post ganglion excision x2 with re-occurrence, left carpal tunnel syndrome, and right DeQuervain's tenosynovitis. Previous treatments included medication management, left wrist surgeries, injections, acupuncture, psychological evaluation, home exercise program, and physical therapy. Previous diagnostic studies include x-rays, nerve conduction studies, and urine drug screening. Report dated 03/10/2015 noted that the injured worker presented with complaints that included right and left wrist pain due to a ganglion cyst. Pain level was not included. Physical examination was positive for abnormal findings. The treatment plan included return in 6 weeks for follow up, refill medications, continue home exercises, awaiting authorization for left ganglion cyst removal, and consideration of right thumb surgery. Disputed treatments include cold therapy sterile wrap (purchase) and cold therapy unit (purchase).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold Therapy Sterile Wrap, Purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder/Continuous-flow cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder/continuous flow cryotherapy.

**Decision rationale:** Guidelines recommend continuous flow cryotherapy as a recommendation as an option after surgery up to 7 days. In this case, the surgery involved a ganglion cyst removal which is not supported for cryotherapy according to guidelines. The request for cold therapy sterile wrap is not medically appropriate and necessary.

**Cold Therapy Unit Purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder/Continuous-flow cryotherapy.

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

**Decision rationale:** Guidelines recommend continuous flow cryotherapy as a recommendation as an option after surgery up to 7 days. In this case, the surgery involved a ganglion cyst removal which is not supported for cryotherapy according to guidelines. The request for cold therapy unit purchase is not medically appropriate and necessary.