

Case Number:	CM13-0025369		
Date Assigned:	11/20/2013	Date of Injury:	02/10/2009
Decision Date:	02/03/2014	UR Denial Date:	09/12/2013
Priority:	Standard	Application Received:	09/17/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice, and is licensed to practice in Texas. 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 physician 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 patient is a 62-year-old female who reported a work related injury on 02/10/2009 when the patient fell and her foot was tangled in the chair that she was sitting on. The patient had complaints of numbness and chronic pain in her neck that radiated down to her bilateral arms at night. The patient also reported numbness to the left arm with a heavy and tight sensation to the last 3 digits of the left hand. The patient underwent left shoulder rotator cuff repair x2 and wrist surgery x2. A request was made for a cold therapy system.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy system: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Continuous-flow cryotherapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Chapter, Durable Medical Equipment

Decision rationale: Recent clinical documentation indicate that the patient complained of cervical spine pain which she rated on a pain scale at 3/10 to 4/10 and she stated that her pain

was decreased. She had received a transcutaneous electrical nerve stimulation (TENS) unit which was very helpful. Physical exam revealed a normal gait and a heel-to-toe walk was performed without difficulty. Physical exam of the cervical spine revealed moderate tenderness over the paraspinal muscle and spasm extending to the trapezius muscles bilaterally. Cervical spine range of motion was only slightly decreased. The patient's shoulder range of motion was within normal limits and orthopedic test for the shoulders were negative with the exception of a positive impingement sign on the right shoulder. Physical exam of the wrists noted range of motion was within normal limits and orthopedic tests were negative. It was noted the patient continued to have considerable neck pain radiating down her left upper extremity and she had been authorized for a left C5-6 and left C6-7 transfacet epidural steroid injection. It was noted the patient would benefit from a hot/cold unit for home use. The California Medical Treatment Guidelines indicate that at home local applications of cold packs during the first few days of acute complaints are recommended; thereafter, applications of heat packs are an optional treatment modality. The Official Disability Guidelines indicate that durable medical equipment is generally recommended if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. The request for a cold therapy system for the patient was not shown to be medically necessary as the patient's injury was on 02/10/2009 and was not shown to be an acute injury requiring cold therapy. The guidelines further state that there is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. Therefore, the decision for cold therapy system is non-certified.