

Case Number:	CM13-0072421		
Date Assigned:	01/03/2014	Date of Injury:	05/18/2011
Decision Date:	06/05/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/31/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/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 injured worker is a 61-year-old male who reported a back and shoulder injury from a fall on 05/18/2011. Within the clinical note dated 11/26/2013, the injured worker reported right shoulder pain rated a 7/10, which radiates into the neck. In addition, the injured worker reported upper and middle back pain rated 5/10. The listed prescribed medication within the clinical note included naproxen 550, Omeprazole 20mg, and hydrocodone 7.5mg. The physical exam revealed unremarkable findings that were consistent with the diagnoses of right shoulder impingement and right shoulder pain. It was reported that the injured worker was scheduled to have shoulder surgery in December. Within the clinical note dated 11/13/2013, there was further discussion and the requested hot/cold unit was indicated to be utilized for thirty (30) days to reduce pain, swelling, edema, and relax muscle spasms. The request for authorization was submitted on 11/13/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

MOTORIZED HOT/COLD UNIT: 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), ONLINE VERSION, SHOULDER (ACUTE AND CHRONIC) CHAPTER, 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: The Official Disability Guidelines recommend cryotherapy as an option after surgery, but not for non-surgical treatment. Postoperative use generally may be up to seven (7) days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The injured worker has not undergone surgical intervention recently, which would indicate the post-operative need for the hot/cold unit. It did not appear that the injured worker would undergo surgical intervention in the near future. Moreover, the submitted request did not indicate the requested duration. Within the clinical records, the provider noted that the intended treatment duration for usage was thirty (30) days, which would exceed the guideline recommendations. Thus, the request is non-certified.