

Case Number:	CM14-0112918		
Date Assigned:	08/01/2014	Date of Injury:	02/16/2014
Decision Date:	09/10/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/18/2014

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 & Rehabilitation, and is licensed to practice in Texas and Oklahoma. 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 30-year-old male who reported an injury on 02/16/2014. The mechanism of injury was not provided. On 05/14/2014, the injured worker presented with pain in the cervical spine, thoracic spine, right shoulder, and chest. Upon examination of the right shoulder, the range of motion values were 160 degrees flexion, and 20 degrees of extension, with a positive empty can test. The diagnoses were cervical spine sprain/strain, thoracic spine sprain/strain, right shoulder sprain/strain. Prior treatment included physical therapy and an arthrogram of the right shoulder. The provider recommended cold therapy unit purchase to the right shoulder and wrist. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit, purchase; right shoulder/wrist: 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 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 request for Cold therapy unit, purchase; right shoulder/wrist is not medically necessary. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. Since the guidelines recommend continuous flow cryotherapy as an option after surgery and not for nonsurgical treatment, cold therapy unit purchase would not be indicated. As such, the request is not medically necessary.