

<b>Case Number:</b>	CM14-0164120		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	07/21/2010
<b>Decision Date:</b>	12/03/2014	<b>UR Denial Date:</b>	09/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2014

### 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 Orthopedic Surgery, has a subspecialty in Sports Medicine and is licensed to practice in Alaska and 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 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 48-year old female who reported an injury on 07/23/2010. The mechanism of injury was not reported. Her diagnoses included cervical and thoracic sprain/strain, cervical and thoracic muscle spasm, cervical radiculitis, right shoulder and elbow sprain/strain, right shoulder adhesive tendinitis, right medial epicondylitis, bilateral wrist sprain/strain, bilateral carpal tunnel syndrome, and right de Quervain's disease. The injured worker's past treatment included surgery, chiropractic treatment, and physical therapy. Diagnostic studies included an MRI of the right shoulder which was performed 07/23/2014 which revealed acromioclavicular joint osteoarthritis, supraspinatus and infraspinatus tendinosis, synovium effusion, subacromial/subdeltoid bursitis, and subcortical cysts in the humeral head. Her surgical history included right carpal tunnel and tennis elbow release performed 08/12/2014 and de Quervains release performed 07/18/2011. The clinical note dated 08/22/2014 reported the injured worker complained of occasional moderate dull, achy neck pain, stiffness, and cramping. Physical examination revealed decreased and painful range of motion and +3 tenderness in the cervical spine, thoracic spine, right shoulder, elbow, and bilateral wrist areas. Current medications were not reported. The treatment plan included continued chiropractic visits 2-3 times per week for 6 weeks. The request was for a Hot & Cold Therapy Unit rental x 4 months to reduce pain. The rationale for the request and the Request for Authorization form was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hot & Cold Therapy Unit rental x 4 months:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**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 a Hot & Cold Therapy Unit rental x 4 months is not medically necessary. The Official Disability Guidelines (ODG) note continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The injured worker was complained of occasional moderate dull, achy neck pain, stiffness, and cramping. The clinical documentation submitted noted the injured worker demonstrated pain and symptoms related to her cervical spine, right shoulder and bilateral wrist areas including muscle spasm and sprain/strain. However, there was a lack of clinical documentation to evidence a plan for or approval of a surgical procedure for the injured worker. The requesting physician's rationale for the request is not indicated within the provided documentation. The request for a cold therapy unit for 4 months would exceed the guideline recommendations as the guidelines recommend use for only 7 days. As such, the request for a Hot & Cold Therapy Unit rental x 4 months is not medically necessary.