

Case Number:	CM14-0178399		
Date Assigned:	10/31/2014	Date of Injury:	05/01/2012
Decision Date:	12/30/2014	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	10/27/2014

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 and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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 patient is a 35 year old female with an injury date of 05/01/12. Based on the treating psychologist's initial report dated 08/18/14, the patient complains of right shoulder and neck pain. Patient is finding it difficult accomplish activities of daily living with ease. As per Peer Review Report dated 09/04/14, physical examination revealed tenderness in the cervical paraspinal region on the right along with tenderness in the midline cervical region. There is tenderness over the left greater occipital nerve and lesser occipital nerve origin. Deep tendon reflexes in the biceps and brachioradialis on the right are +1. Shoulder Elevation Abduction test is positive. Head Compression test leads to discomfort while Spurling's test is painful. Sensory examination shows decreased sensation to light touch at right C4, C5, C6, C7 and C8 nerve direction. The cervical range of motion was diminished and there was a spasm in the cervical spine. The patient underwent right shoulder surgery on 10/18/12 and cervical spine displacement surgery 06/25/13, as per progress report dated 08/18/14. The patient also received cortisone injection and physical therapy, as per the same report. Recent medications include Naproxen, Ambien, Hydrocodone, and Orphenadrine citrate. Diagnosis, 08/18/14- Right shoulder pain- Neck pain. The provider is requesting for motorized cold therapy unit for the neck and right shoulder - purchase. The utilization review determination being challenged is dated 10/14/14. The rationale was "the motorized cold therapy unit is not supported for the neck and right shoulder." Treatment report was dated 08/18/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized cold therapy unit for the neck and right shoulder-purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Shoulder Chapters, 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 (Acute & Chronic), Continuous-flow Cryotherapy, Neck & Upper Back (Acute & Chronic), Continuous-flow Cryotherapy

Decision rationale: ODG Guidelines, Shoulder chapter (Acute & Chronic), Continuous-flow Cryotherapy, has the following regarding continuous-flow cryotherapy: "Recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." ODG guidelines, Neck and Upper Back (Acute & Chronic) chapter, Continuous-flow Cryotherapy, state that this treatment is "Not recommended in the neck." In this case, the patient underwent right shoulder surgery on 10/18/12 and cervical spine displacement surgery 06/25/13, as per psychologist's initial report dated 08/18/14. A motorized cold therapy unit may help reduce pain and narcotic use in the shoulder. ODG guidelines recommend the use of such device for up to 7 days. However, the provider is requesting for a purchase instead of 7-day rental. Additionally, the guidelines do not recommend use for neck pain. Recommendation is for denial.