

Case Number:	CM14-0070198		
Date Assigned:	07/14/2014	Date of Injury:	05/23/2013
Decision Date:	10/17/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	05/15/2014

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 Anesthesiology and Pain Medicine, and is licensed to practice in Florida. 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 43-year-old male who reported an injury on 05/23/2013 due to an unknown mechanism. Diagnoses were chronic cervical musculoligamentous sprain/strain with 3 mm herniation, per MRI; anterior cervical fusion decompression of the cervical spine; lumbar disc annular tear; left shoulder posterior labral tear; left shoulder subacromial impingement and rotator cuff tendinitis; bilateral chondromalacia patella; status post fall injury to the right shoulder; right shoulder arthroscopic subacromial decompression; status post left knee arthroscopic surgery with medial meniscal repair; L4-5 and L5-S1 annular tears with 2 to 3 mm disc protrusions; gastropathy secondary to medication intake. Past treatments were physical therapy, acupuncture, and medications. Diagnostic studies were MRI of the lumbar spine. Surgical history was a cervical fusion decompression, right shoulder arthroscopic subacromial decompression, left knee arthroscopic surgery with medial meniscal repair on 09/2003. Physical examination on 06/06/2014 revealed limited range of motion. There was tenderness noted over the trapezius and paravertebral muscles equally. Shoulder decompression test and Spurling's test was positive bilaterally. Muscle strength was 4/5 bilaterally at the C5 nerve root and 5/5 at C6, C7 and C8 nerve roots. Sensation was decreased at 4/5 in the C5 nerve distribution bilaterally. There is tenderness noted over the paraspinal muscles equally. Kemp's test was positive bilaterally at the lumbar spine. Examination of the left shoulder revealed decreased range of motion with flexion and abduction. There was tenderness noted over the acromioclavicular joint. There was decreased range of motion for bilateral knees. There was tenderness noted over the medial and lateral joint lines bilaterally. Patellofemoral grind test was positive. Medications were Motrin, Prilosec, Anexsia, and Ultram. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cryotherapy 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 Treatment Updated December 27, 2013, Integrated Treatment/Disability Duration Guidelines Shoulder (Acute & Chronic) Cryotherapy Units <http://worklossdatainstitute.verioiponly.com>

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 decision for cryotherapy unit is not medically necessary. The Official Disability Guidelines states a continuous flow cryotherapy unit is 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 usage, however, the effect on more frequently treated acute injuries (e.g. muscle strains and contusions) has not been fully evaluated. Continuous flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. The clinical documentation submitted for review does not provide information to support the request for a cryotherapy unit. It was not reported what part of the body the cryotherapy unit was to be used for. There were no significant factors reported to justify the use of a cryotherapy unit. Therefore, this request is not medically necessary.