

Case Number:	CM14-0078816		
Date Assigned:	07/18/2014	Date of Injury:	01/14/2010
Decision Date:	09/18/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/29/2014

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, 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 injured worker is a 60-year-old female, who reported an injury after a motor vehicle accident 01/14/2010. The clinical note, dated 03/19/2014, indicates diagnoses of right wrist and hand strain/sprain, carpal tunnel syndrome, right elbow strain/sprain, lateral medial epicondylitis, cubital tunnel syndrome, right shoulder strain/sprain, partial tear of supraspinatus tendon status post arthroscopy with subacromial decompression dated 03/08/2014, symptoms of anxiety and depression, diabetes mellitus, status post open reduction internal fixation bimalleolar fracture of the left ankle in 2007, symptoms of insomnia, and hypertension. The injured worker was status post right shoulder arthroscopic surgery, date of 03/08/2014. The injured worker rated her pain level as 7/10. She complained of anxiety and depression. On physical examination of the right shoulder, there was a well healed scar; incision is dry and intact without evidence of infection. The injured worker's treatment plan included removal of the sutures and application of sterile dressing, refill medications of Ultram, Xanax, and Ambien, postop physical therapy 2 times a week for the next 6 weeks, and follow-up visit in 2 weeks. The injured worker's prior treatments included diagnostic imaging and medication management. The injured worker's medication regimen included Ultram, Xanax, and Ambien. The provider submitted a request for a cold therapy unit. A Request for Authorization, dated 04/21/2014, was submitted for a cold therapy unit. However, a rationale is not provided 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 - (Unspecified if rental/purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross/Blue Shield policy (Cooling Devices Used in the Home Setting, DME Policy No: 7).

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 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. 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 (eg, 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. Complications related to cryotherapy (i.e, frostbite) are extremely rare but can be devastating. The provider did not indicate a rationale for the request. In addition, the request did not indicate a body part or if the injured worker will be participating in a physical therapy program. Additionally, it was not indicated if the cold therapy unit would be for rental or purchase. Furthermore, the request did not indicate a time frame for the cold therapy unit. Therefore, the request is not medically necessary.