

<b>Case Number:</b>	CM14-0089039		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	04/04/2011
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	05/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2014

### 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 Internal Medicine and Emergency 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:

This patient is a 50 year-old with a date of injury of 04/04/11. A progress report associated with the request for services, dated 06/21/11, reported subjective complaints of right shoulder, cervical, and thoracic pain. Objective findings included tenderness to palpation of the shoulder and cervical spine. Decreased sensation was noted in the right hand. Diagnoses included (paraphrased) cervical disc disease; right rotator cuff sprain; and myofascial pain. A Utilization Review determination was rendered on 05/19/14 recommending non-certification of "56 Day rental of thermocool contrast system retro 07/01/11; 56 Day rental of thermocool circulating cold/heat pad retro 07/01/11; 98 day rental of cervical traction retro 07/01/11".

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **56 Day rental of thermocool contrast system retro 07/01/11: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disabilities guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203; 212.

**Decision rationale:** Thermocool hot and cold contrast therapy is a device that provides alternating hot and cold therapy. The Medical Treatment Utilization Schedule (MTUS) states

that at-home applications of heat or cold packs to aid exercises are optional. There is no recommendation for alternating heat and cold using a device other than non-mechanical application of heat or cold packs. They do not address continuous-flow therapy specifically. The Official Disability Guidelines (ODG) states that continuous-flow cryotherapy is not recommended for the neck. It is recommended as an option after shoulder surgery, but not for nonsurgical treatment. Postoperative use may be up to 7 days. Therefore, in this case, the request is beyond the recommended treatment period and for an indication not recommended.

**56 Day rental of thermocool circulating cold/heat pad retro 07/01/11: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disabilities guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203; 212.

**Decision rationale:** Thermocool hot and cold contrast therapy is a device that provides alternating hot and cold therapy. The Medical Treatment Utilization Schedule (MTUS) states that at-home applications of heat or cold packs to aid exercises are optional. There is no recommendation for alternating heat and cold using a device other than non-mechanical application of heat or cold packs. They do not address continuous-flow therapy specifically. The Official Disability Guidelines (ODG) states that continuous-flow cryotherapy is not recommended for the neck. It is recommended as an option after shoulder surgery, but not for nonsurgical treatment. Postoperative use may be up to 7 days. Therefore, in this case, the request is beyond the recommended treatment period and for an indication not recommended. As such, neither the thermocool unit or its associated pads are medically necessary.

**98 day rental of cervical traction retro 07/01/11: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-4. Decision based on Non-MTUS Citation Official disabilities guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 8 Neck and Upper Back Complaints Page(s): 49; 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back, Traction.

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) states that cervical traction is not recommended as initial therapy for disorders of the cervical spine. The Chronic Pain Guidelines do not address cervical traction. The Official Disability Guidelines (ODG) states that home cervical patient controlled traction is recommended for cervical spine syndromes with radiculopathy. In this case, a radiculopathy was not been firmly established. Therefore, the medical record does not document the medical necessity for cervical traction.