

Case Number:	CM14-0188826		
Date Assigned:	11/19/2014	Date of Injury:	10/06/2003
Decision Date:	01/07/2015	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	11/12/2014

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 Pain Management 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:

This patient sustained an injury on 10/6/2003 while employed by [REDACTED]. Request(s) under consideration include Medrol dose pack, Ice therapy, and Polar Ice Unit. Diagnoses include cervical radiculopathy; lumbar radiculopathy; and right shoulder impingement syndrome. Conservative care has included medications, therapy, and modified activities/rest. Report of 9/2/14 from the provider noted chronic ongoing neck, shoulder and low back pain associated with numbness and weakness in bilateral upper extremities. Exam showed limited cervical spine range with pain on extension; limited low back range with tightness of hamstring; weakness of eversion; subacromial tenderness with right shoulder pain on cross reach with positive Hawkin's and Neer's testing. Treatment included medications, Voltaren gel, ice therapy, and Facet injections. The patient remained retired. The request(s) for Medrol dose pack, Ice therapy, and Polar Ice Unit were non-certified on 10/21/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medrol dose pack: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Oral corticosteroids, page 624

Decision rationale: This patient sustained an injury on 10/6/2003 while employed by [REDACTED]. Request(s) under consideration include Medrol dose pack, Ice therapy, and Polar Ice Unit. Diagnoses include cervical radiculopathy; lumbar radiculopathy; and right shoulder impingement syndrome. Conservative care has included medications, therapy, and modified activities/rest. Report of 9/2/14 from the provider noted chronic ongoing neck, shoulder and low back pain associated with numbness and weakness in bilateral upper extremities. Exam showed limited cervical spine range with pain on extension; limited low back range with tightness of hamstring; weakness of eversion; subacromial tenderness with right shoulder pain on cross reach with positive Hawkin's and Neer's testing. Treatment included medications, Voltaren gel, ice therapy, and Facet injections. The patient remained retired. The request(s) for Medrol dose pack, Ice therapy, and Polar Ice Unit were non-certified on 10/21/14. Per the guidelines, oral corticosteroids (Medrol Dose pack) are not recommended for acute, sub-acute and chronic spine and joint pain due to the lack of sufficient literature evidence (risk vs. benefit, lack of clear literature) and association with multiple severe adverse effects with its use. There is also limited available research evidence which indicates that oral steroids do not appear to be an effective treatment for patients with spine and joint problems and has serious potential complications associated with long-term use. Submitted reports have not demonstrated specific indication and support for use outside guidelines criteria for this chronic 2003 injury without demonstrated functional improvement from medications already received. The Medrol dose pack is not medically necessary and appropriate.

Ice therapy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 173-174, 203 & 300. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletins

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, pages 909-910: 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

Decision rationale: Polar Ice Unit. Diagnoses include cervical radiculopathy; lumbar radiculopathy; and right shoulder impingement syndrome. Conservative care has included medications, therapy, and modified activities/rest. Report of 9/2/14 from the provider noted chronic ongoing neck, shoulder and low back pain associated with numbness and weakness in bilateral upper extremities. Exam showed limited cervical spine range with pain on extension; limited low back range with tightness of hamstring; weakness of eversion; subacromial tenderness with right shoulder pain on cross reach with positive Hawkin's and Neer's testing. Treatment included medications, Voltaren gel, ice therapy, and Facet injections. The patient remained retired. The request(s) for Medrol dose pack, Ice therapy, and Polar Ice Unit were non-

certified on 10/21/14. Regarding Cold therapy, guidelines state it 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 request for authorization does not provide supporting documentation for use beyond the guidelines criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines. The request for Polar Ice Unit and ice therapy does not meet the requirements for medical necessity. MTUS Guidelines is silent on its specific use but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post-surgery; however, limits the use for 7-day post-operative period as efficacy has not been proven after. The Ice Therapy is not medically necessary and appropriate.

Polar ice unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 173-174, 203 & 300. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletins

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, pages 909-910: 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

Decision rationale: This patient sustained an injury on 10/6/2003 while employed by [REDACTED]. Request(s) under consideration include Medrol dose pack, Ice therapy, and Polar Ice Unit. Diagnoses include cervical radiculopathy; lumbar radiculopathy; and right shoulder impingement syndrome. Conservative care has included medications, therapy, and modified activities/rest. Report of 9/2/14 from the provider noted chronic ongoing neck, shoulder and low back pain associated with numbness and weakness in bilateral upper extremities. Exam showed limited cervical spine range with pain on extension; limited low back range with tightness of hamstring; weakness of eversion; subacromial tenderness with right shoulder pain on cross reach with positive Hawkin's and Neer's testing. Treatment included medications, Voltaren gel, ice therapy, and Facet injections. The patient remained retired. The request(s) for Medrol dose pack, Ice therapy, and Polar Ice Unit were non-certified on 10/21/14. Regarding Cold therapy, guidelines state it is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. Submitted reports have not provided adequate documentation, risk factors, or comorbidities to support for the request beyond guidelines' criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines. MTUS Guidelines is silent on the specific use of Polar care, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post-surgery; however, limits the use for 7-day in the post-operative period as efficacy has not been proven after. The Polar Ice Unit is not medically necessary and appropriate.