

Case Number:	CM14-0191053		
Date Assigned:	11/24/2014	Date of Injury:	08/21/2012
Decision Date:	01/09/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	11/17/2014

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 Family Medicine 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 65-year old retail associate reported injuries to her neck, upper back, right shoulder and right elbow due to plastic containers and boxes falling onto her neck and shoulder on 7/23/12. After an initial course of treatment, she was made permanent and stationary with 5% whole person impairment in 12/12, at which time she was working without restrictions. She retired 6/18/13, purportedly because she could not work due to pain, and has not worked since. She has subsequently claimed diagnoses of depression and anxiety due to her injury. Treatment since 2012 has included medications, extensive physical therapy, a trapezius muscle injection, and cervical epidural steroid injections. She has not had any surgery. The most recent progress note in the available records from her primary provider is dated 7/7/14. It documents that the patient has ongoing moderate to severe pain in the right neck, shoulder and arm, with tingling and weakness in the right arm and hand. Physical findings included full neck range of motion and limited shoulder range of motion. Spurling's test was positive, as were tests for shoulder impingement. Diagnoses included cervicgia with cervical disc displacement, and "unspecified polyarthropathy or polyarthritis involving the shoulder". The plan included a review of a surgical consult which revealed that the patient was not a surgical candidate for neck surgery, and review of a right shoulder MRI which showed a full thickness supraspinatus tear and AC hypertrophy. Tramadol was continued, heat therapy was recommended for the neck, and an orthopedic consultation for the shoulder was requested, as well as aquatic therapy. An orthopedist saw the patient on 10/24/14. Physical findings included markedly limited right shoulder range of motion. Diagnoses included right shoulder capsulitis/frozen shoulder, right partial rotator cuff tear, and right cervical radiculopathy. A request was made for right shoulder surgery consisting of manipulation under anesthesia and a capsular release, with a possible rotator cuff repair. A request for authorization of an arthroscopic capsular release of the right

shoulder was made on 10/28/14. Apparently a separate request for authorization of a 7-day rental of a cold therapy unit was also made, but the available records do not contain a copy of it. The request for the cold therapy unit was denied in UR on 10/31/14 on the basis that cryotherapy is only recommended as an option after surgery, and that no surgery had been authorized.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy Unit (7 day rental): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Web, Knee and Leg (Acute and Chronic), 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 chapter, cold compression therapy, and continuous flow cryotherapy Other Medical Treatment Guideline or Medical Evidence: ACOEM Guidelines, Updated Chronic Pain Section, Page 166, Cryotherapies.

Decision rationale: The ODG citations above state that cold compression therapy is not recommended for the shoulder, because there are no published studies. Continuous flow cryotherapy is recommended as an option after shoulder surgery, but not for nonsurgical treatment. Postoperative use may be for up to 7 days, including home use. The updated ACOEM chronic pain guidelines state that Examples of cryotherapy include towels moistened with cold water, ice wrapped in a blanket, ice massage, cold water and/or ice placed in a "water bottle," gel packs, cooling sprays, or single-use chemical packets that produce cooling on breaking one pouch inside the other to start a chemical reaction. Routine use of cryotherapies in health care provider offices or the use of high tech devices is not recommended for treatment of any chronic pain condition. The clinical documentation available to me does not support the provision of a cold therapy unit to this patient. There is no documentation which states what specific type of unit is being requested, and for what reason. Requests for postsurgical continuous cold therapy units are typically requested with the request for the surgery involved. Since that is not the case in this situation, it cannot be assumed that the unit is intended for postsurgical use. Even if it is intended for postsurgical use, it cannot be assumed that the unit being requested is a continuous cold therapy unit rather than a cold compression device, which would not be indicated. Additionally, there is no documentation that surgery has been authorized. High tech cold therapy devices are not recommended by the ACOEM guideline above for treatment of non-surgical chronic pain. Based on the clinical information provided for my review and on the evidence-based citations above, a cryotherapy unit is not medically necessary for this patient. It is not medically necessary because it is not clear what kind of unit is requested and what setting it is to be used, and because no surgery has been authorized which would make continuous flow cryotherapy an option. The request is not medically necessary.