

Case Number:	CM14-0198336		
Date Assigned:	12/08/2014	Date of Injury:	04/20/2013
Decision Date:	01/26/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/25/2014

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 Rehab, has a subspecialty in Interventional Spine 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 patient is a 48 year old female with an injury date on 4/20/13. The patient complains of increased right shoulder pain per 9/22/14 report. The patient complains of ongoing cervical pain rated 8/10 with achy symptoms along posterior part of the neck which increases with head movement per 8/11/14 report. The pain also radiates along the right anterior upper extremity to the hand per 8/11/14 report. The patient states that her symptoms affect her sleep and activities of daily living and that cortisone injections in the past have failed, per a 9/22/14 report. Based on the 9/22/14 progress report provided by the treating physician, the diagnoses are: 1. cervical disc syndrome; 2. right shoulder rotator cuff syndrome; 3. lumbar facet syndrome; 4. right shoulder impingement; 5. right medial epicondylitis; 6. right carpal tunnel syndrome. A physical exam on 9/22/14 showed "reduced range of motion of right shoulder with flexion reduced 40 degrees, and normal range of motion of left shoulder." The patient's treatment history includes medications (ibuprofen only), physical therapy, and acupuncture. The treating physician is requesting cold therapy unit for 30 to 45 days. The utilization review determination being challenged is dated 10/29/14. The requesting physician provided treatment reports from 4/22/14 to 9/22/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit for 30 to 45 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, 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 section on Continuous-flow cryotherapy

Decision rationale: This patient presents with right shoulder pain, neck pain, right upper extremity/hand pain. The treating physician has asked for Cold therapy unit for 30 to 45 days but the requesting progress report is not included in the provided documentation. The patient is awaiting authorization for right shoulder arthroscopic surgery as she has positive MRI findings and failed conservative measures including cortisone injections, physical therapy and medication per 9/22/14 report. The patient will need a sling with pillow, shoulder exercise kit, and a cold therapy unit postoperatively per 9/22/14 report. Regarding cryotherapy, ODG allows for short-term post-operative use for 7 days. ODG states that no research shows any additional added benefit for more complicated cryotherapy units over conventional ice bags or packs. In this case, the patient will undergo an arthroscopic shoulder surgery and the treating physician is requesting a post-operative cryotherapy unit. ODG guidelines allow 7 day use, however, and the requested 30-45 days of use are not indicated. The request is not medically necessary.