

Case Number:	CM15-0001684		
Date Assigned:	01/12/2015	Date of Injury:	02/10/1980
Decision Date:	08/24/2015	UR Denial Date:	12/10/2014
Priority:	Standard	Application Received:	01/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 61 year old male, who sustained an industrial injury on 2/10/1980. The mechanism of injury is unknown. The injured worker was diagnosed as having left shoulder gleno-humeral osteoarthritis, full thickness tear of the supraspinatus, chronic lumbar strain and chronic left knee strain. There is no record of a recent diagnostic study. Treatment to date has included therapy and medication management. In a progress note dated 11/26/2014, the injured worker complains of intermittent low back pain-rated 2/10 and pain in the left shoulder-rated 5/10, right shoulder-rated 3-4/10, left knee-rated 1-3/10 and left foot-rated 1/10. Physical examination showed right shoulder decreased rotation due to pain, left shoulder tenderness with limited range of motion and lumbar tenderness with decreased range of motion. The treating physician is requesting cold therapy machine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy machine: 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 (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Continuous-flow cryotherapy.

Decision rationale: The MTUS is silent on the use of cold therapy units. The ODG states continuous-flow cryotherapy is "Recommended 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. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting." The documentation submitted for review does not indicate that the injured worker is postoperative or pending surgery. As the ODG only supports the use of cold therapy units as an option after surgery, the request is not medically necessary.