

<b>Case Number:</b>	CM15-0105516		
<b>Date Assigned:</b>	06/09/2015	<b>Date of Injury:</b>	03/31/2012
<b>Decision Date:</b>	07/10/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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, Indiana, New York  
Certification(s)/Specialty: Internal Medicine

### 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 35 year old female who sustained an industrial injury on 03/31/2012. There was no mechanism of injury documented. The injured worker was diagnosed with status post cervical spine and shoulder surgery and headaches. The injured worker underwent a right shoulder arthroscopy with debridement of a partial thickness rotator cuff tear in October 2012 and total disc arthroplasty in June 2013. The injured worker has had diagnostic testing, surgery, nerve blocks, neurologist consultation with follow-up and pain management therapy. According to the primary treating physician's progress report on May 1, 2015, the injured worker was evaluated for exacerbation of pain. The injured worker reported that the left sided neck was so severe she was unable to move her left arm. She was seen in the emergency room and treated with Dilaudid. Examination demonstrated decreased range of motion of the cervical spine with positive head compression test causing neck pain. Reflexes were noted to be symmetrical with bilateral upper extremity sensation intact. Current medications were noted as Norco, Naprosyn, Ambien, Orphenadrine and Colace. Treatment plan consists of the current request for a motorized cold therapy unit for purchase.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Motorized Cold Therapy Unit for purchase: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, Cold therapy unit.

**Decision rationale:** Pursuant to the ACOEM and Official Disability Guidelines, motorized cold therapy unit purchase is not medically necessary. "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living". Continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use maybe for up to seven days, including home use. In the post operative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling and narcotic use; however the effect on more frequently treated acute injuries has not been fully evaluated. Cold/heat packs are recommended as an option for acute pain. At home local applications of cold packs in the first few days of acute complaint; thereafter, application of heat packs or cold pack. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. Evidence for application of cold treatment to low back pain is more limited than the therapy. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal activities. In this case, the injured worker's working diagnoses are neck pain, status post total disc arthroplasty at C4 - C5 in June 2013 with residual pain and headache; and right shoulder pain, status post right shoulder arthroscopy October 2012. The treating provider is requesting a motorized cold therapy unit for purchase to be utilized post injection (epidural steroid injection). According to the ACOEM: "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications." During the acute to subacute phases for period of two weeks, providers can use passive modalities such as heat or cold or temporary amelioration of symptoms. The guidelines do not recommend heat/cold modalities in the chronic setting and, moreover, do not recommend purchase of a motorized cold therapy unit and a chronic setting or post injection setting. Consequently, absent guideline recommendations for a motorized cold therapy unit, motorized cold therapy unit purchase is not medically necessary.