

Case Number:	CM15-0144612		
Date Assigned:	08/05/2015	Date of Injury:	12/17/2008
Decision Date:	09/02/2015	UR Denial Date:	07/09/2015
Priority:	Standard	Application Received:	07/27/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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:

This is a 51-year-old female with a December 17, 2008 date of injury. A progress note dated May 19, 2015 documents subjective complaints (continues to have shoulder pain with overhead activities and pain that awakens her at night when she rolls on to the left shoulder), objective findings (range of motion of the neck is good but stiff; tenderness to palpation throughout the cervical spine paraspinals; decreased range of motion of the left shoulder; rotator cuff testing decreased with pain), and current diagnoses (rotator cuff sprain and strain; other affections of the shoulder region; adhesive capsulitis of the shoulder). Treatments to date have included home exercise, physical therapy, and medications. The treating physician documented a plan of care that included a thirty-day rental of a cold compression unit for left shoulder following surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold compression unit for left shoulder, thirty 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cold/heat packs.(http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT).

Decision rationale: According to ODG guidelines, cold therapy is "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) 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 function. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel". In this case, the patient underwent shoulder arthroscopic surgery on July 2, 2015 and there is not enough documentation to determine the medical necessity for cold therapy. There are no controlled studies supporting the use of hot/cold therapy in neck and shoulder pain. Therefore, the request for Cold compression unit for left shoulder, thirty-day rental is not medically necessary.