

<b>Case Number:</b>	CM15-0185790		
<b>Date Assigned:</b>	09/28/2015	<b>Date of Injury:</b>	03/15/2010
<b>Decision Date:</b>	11/10/2015	<b>UR Denial Date:</b>	08/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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:

The injured worker is a male worker who sustained an industrial injury on July 11, 2007. A primary treating office visit dated May 01, 2015 reported the worker being diagnosed with herniated disc at L3-4 that is left sided with right sided symptoms. The plan of care noted recommendation for a re-repeat magnetic resonance imaging of lumbar spine since "I can palpate his spine and spinous process." Naprosyn and Tramadol were refilled. Primary follow up dated June 12, 2015 reported subjective complaint of radiating right leg pain. The diagnosis of rule out bilateral pars fracture at L3 was added this visit. The plan of care is with recommendation for a computerized tomography scan of lumbar spine and neurology evaluation and nerve conduction study of lower extremities. On August 11, 2015 formal request was made for electric diagnostic nerve conduction study of bilateral lower extremities was non-certified by utilization Review on August 19, 2015. There is an operative report dated 8/21/15 that states that the patient had arthroscopic right shoulder surgery for advanced impingement syndrome and a mini open technique with biceps tenodesis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pneumatic intermittent compression device:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Section: 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) Shoulder- Cold compression therapy and compression garments.

**Decision rationale:** Pneumatic intermittent compression device are not medically necessary per the ODG. The ODG states that cold compression therapy and compression garments are not medically necessary per the ODG. The MTUS does not specifically address this request. The ODG states that neither cold compression therapy or compression garments are recommended for the shoulder, as there are no published studies. It may be an option for other body parts. The documentation does not reveal extenuating circumstances that support this request therefore this request is not medically necessary.

**Cold therapy unit with pad (purchase):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Section: 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) Shoulder- Continuous-flow cryotherapy.

**Decision rationale:** Cold therapy unit with pad (purchase) is not medically necessary per the ODG. The MTUS does not specifically address this request. Continuous-flow cryotherapy is not medically necessary per the ODG. The ODG states that this is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. This documentation reveals no extenuating circumstances why a cold therapy unit is necessary for this patient as a purchase and beyond the 7 day postoperative use period. This request is not medically necessary.