

<b>Case Number:</b>	CM15-0204894		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	12/09/1997
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	09/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/19/2015

### 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 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 56 year old male, who sustained an industrial injury on 12-9-1997. The injured worker is undergoing treatment for: pain to the neck, bilateral shoulders and low back, rotator cuff syndrome, cervical post-laminectomy syndrome. On 5-7-15 and 6-10-15, he reported pain to the neck, upper back, mid back, low back, and bilateral shoulders with radiation into the right arm, and associated numbness and tingling in bilateral hands and feet, and weakness of bilateral arms. He rated his pain as 8-9 out of 10. He indicated his pain to have been unchanged since his injury. Physical findings revealed decreased neck range of motion, tenderness in the bilateral trapezii, negative spurling's maneuver bilaterally, decreased bilateral shoulder range of motion, tenderness in the bilateral shoulders, positive hawkin's on the right and yergason's testing on the left, and decreased right shoulder strength and grip strength on the right. The treatment and diagnostic testing to date has included: medications, multiple physical therapy sessions, MRI of the cervical spine (date unclear), cervical spine surgery (date unclear), right shoulder surgery (7-8-2014). Medications have included: naproxen, omeprazole, losartan, atenolol, atorvastatin. Current work status: not working. The request for authorization is for: one cold therapy unit (14 day rental). The UR dated 9-19-2015: non-certified the request for one cold therapy unit (14 day rental).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold Therapy Unit (14 day rental): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, 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) Cold Therapy.

**Decision rationale:** According to ODG, the home application of cold packs is just as effective as those performed by a therapist. A cold therapy unit is not-supported at this time. If cold therapy is desired, cold packs are readily available. There is no specific indication for a cold therapy unit. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.