

Case Number:	CM15-0036613		
Date Assigned:	03/05/2015	Date of Injury:	04/14/2002
Decision Date:	04/15/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	02/26/2015

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: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 applicant is a represented [REDACTED] beneficiary who has filed a claim for chronic neck, shoulder, and low back pain, reportedly associated with an industrial injury of April 14, 2002. In a Utilization Review Report dated January 15, 2015, the claims administrator denied a cold therapy unit 7-day rental for the shoulder. The claims administrator referenced a January 9, 2015, progress note in its determination. The claims administrator apparently denied the request for postoperative cryotherapy on the grounds that a concomitant request for shoulder surgery had also been denied. The applicant's attorney subsequently appealed. On January 9, 2015, authorization was sought for shoulder diagnostic arthroscopy on the grounds that the applicant had failed corticosteroid injection therapy and physical therapy. The request for postoperative cryotherapy was, thus, seemingly endorsed in conjunction with request for shoulder surgery. The remainder of the file was surveyed. There was no evidence that the applicant underwent, was scheduled to undergo, and/or had received the shoulder surgery, which was also the subject of dispute.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit 7 day rental to the left shoulder: 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), Shoulder, Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Recommendation: Home Use of Cryotherapies for Acute, Subacute, Chronic, or Peri-operative Shoulder Pain Cryotherapies are recommended for home use if efficacious for the temporary relief of acute, subacute, chronic, or peri-operative shoulder pain. Indications Acute, subacute, chronic, or peri-operative shoulder pain. Indications for Discontinuation Non-tolerance, including exacerbation of shoulder pain. Strength of Evidence Recommended, Insufficient Evidence (I) Rationale for Recommendation. There are no quality trials for treatment of shoulder pain patients. There is one moderate-quality trial for post-operative treatment; however, there were no clinical results. (673) Education regarding home cryotherapy application may be part of the treatment if cold is effective in reducing pain. Self applications of cryotherapies using towels or reusable devices are non-invasive, minimal cost, and without complications. Other forms of cryotherapy can be considerably more expensive, including chemicals or cryotherapeutic applications in clinical settings and are not recommended.

Decision rationale: No, the request for a cold therapy unit, seven-day rental was not medically necessary, medically appropriate, or indicated here. The MTUS does not address the topic of postoperative cryotherapy. While the Third Edition ACOEM Guidelines do acknowledge that cryotherapies are recommended for home use for perioperative shoulder pain, in this case, however, the request for shoulder surgery was concomitantly denied. There was no evidence that the applicant had either received, had underwent, and/or scheduled to undergo the shoulder surgery, which was also the subject of dispute. Therefore, the request was not medically necessary.