

Case Number:	CM15-0052841		
Date Assigned:	03/26/2015	Date of Injury:	08/31/2013
Decision Date:	05/01/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	03/19/2015

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: 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 61-year-old who has filed a claim for chronic neck, shoulder, and elbow pain reportedly associated with an industrial injury of August 31, 2013. In a Utilization Review report dated February 23, 2015, the claims administrator failed to approve a request for motorized hot and cold therapy unit. An RFA form received on February 16, 2015 was referenced in the determination. The applicant's attorney subsequently appealed. On December 19, 2014, the applicant reported multifocal complaints of neck and shoulder pain. Motrin, Prilosec, Flexeril, Theramine, GABAdone, other dietary supplements, multiple topical compounds were endorsed, along with motorized cold therapy unit for the neck and shoulder. Manipulative therapy, acupuncture, physical therapy, orthopedic shoulder surgery consultation, and urine drug testing were endorsed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized Hot/Cold Therapy Unit cervical/Bilateral shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 174; 203. Decision based on Non-MTUS Citation ACOEM V.3.

Decision rationale: No, the request for a motorized hot and cold therapy unit for the cervical spine and bilateral shoulder was not medically necessary, medically appropriate, or indicated here. While the MTUS Guidelines in ACOEM Chapter 9, Table 9-3, page 204 and Chapter 8, Table 8-5, page 174 do recommend at-home local applications of heat and cold as methods of symptom control neck, upper back, and shoulder pain complaints, as were/are present here, by implication, ACOEM does not support high tech devices for administering and/or delivering cryotherapy, as was proposed here. The Third Edition ACOEM Guidelines takes more explicit position against the usage of such devices, explicitly stating that such high tech devices for delivering cryotherapy are deemed "not recommended." Here, the attending provider documentation was sparse, thinly developed, difficult to follow, contained little-to-no narrative commentary, and did not furnish any compelling applicant-specific rationale which would offset the unfavorable ACOEM positions on the article at issue. Therefore, the request was not medically necessary.